THE University of Vermont MEDICAL CENTER

INTEGRITY AND COMPLIANCE DEPARTMENT
COVERAGE ANALYSIS AND BUDGETING

I. Clinical Trial Coverage Analysis Information

1. **Principal Investigator:** **CHRMS/CHRBS (if known)_____**

2. **Protocol Title:**

3. **Sponsor:**

4. Is this a treatment trial or does it have therapeutic intent?
   ☐ Yes ☐ No

Please submit a signed copy of this form along with a scan of the IRB submission packet electronically to:

Compliance@UVMHealth.org
Cc: denise.quint@UVMHealth.org
Denise Quint, CPC, CHC, CHRC
Phone: 847-9482

II. Department Budgeting

1. Is personnel time of any of the following individuals necessary to conduct this research, and if so, is funding for that time included in the budget?

	Resources	Funding/Support
Principal Investigator	___ Yes ___ No	___ Yes ___ No
Clinical Research Coordinator(s)	___ Yes ___ No	___ Yes ___ No
Clinical Research Nurse	___ Yes ___ No	___ Yes ___ No

2. Funding Source if costs exceed budget: _____

Investigator Attestation:

I understand that changes made to the supporting study documentation such as the sponsor agreement, informed consent form, study budget, etc. can impact the outcome of the Medicare Coverage Analysis and I will communicate all changes in study supporting documentation (i.e. protocol amendments, consent forms, contracts) to the Integrity and Compliance Department.

I understand that the Integrity and Compliance Department may contact me to request further documentation.

Print Name of PI:_____ Phone: _____Department:_____

PI Signature:_____Date: _____

Health Care Service Leader Signature: _____Date: _____