



GHS Product Evaluation/Request Form

Physician/Clinician is requesting temporary trial of Product? Yes No

Item Information

Item Description: _____ Item Each Cost: _____

Manufacturer/Supplier/Product Info Attached: _____ Mfg/Catalog Number: _____

Vendor Representative: _____

Telephone: _____

Requesting Department/Person: _____

What is this item used for? _____

Is this item going to replace an item that is currently used? Yes No

If Yes please list what product this will replace: _____

Physician requesting: _____

Physician Contact info: _____

MSDS required? Yes No

Does product contain any type of carbon base tissue (human, bovine, etc)? Yes No

Is this product latex free? Yes No

HCPCS, C-Code, or CPT Code: _____

*****Please attach any reimbursement summary available for this product along with this request*****

Contracting Information:

Yes No

 On Premier or Local GHS Contract? Contract Number: _____

 Is Consignment available for product?

 Is item FDA approved?

 Is item patient chargeable?

 Does item require purchase or lease of equipment?

Financial Analysis (To be performed by Materials Management):

Item for Item Replacement

Cost of Old Item _____

Cost of New Item _____

Incremental Savings (Cost) \$ _____ -

Annual Utilization of Old Item _____

Annual Savings (Cost) \$ _____ -



<u>Incremental Item Addition – without Reimbursement</u>	
Cost of New Item _____	Inventory Qty _____
Projected Annual Utilization _____	Cost per Item _____
Projected Annual Cost \$ _____ -	Inv Value \$ _____ -

New Product/Technology Meeting Outcome

- Approved for immediate Use
- Approved for Evaluation
- Resubmit with more data
- Rejected

Information to be sent to Chargemaster if Approved:

MM Meditech Number: _____
 Cost (EA): _____
 Patient Charge: _____

Evaluation Start Date: _____ End Date: _____
 Final Education Date: _____ End Date: _____

Dept. Manager Signature: _____ Date: _____

Materials Management Signature: _____ Date: _____

Contact Information:

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