EP 6.17-A
Request for New Clinic Procedures Approval Form
To be completed by requesting physician

Name of requesting physician: _____________________________________________________

Requested Procedure: _____________________________________________________________

Department/Clinic: _______________________________________________________________

Description: Describe the procedure or treatment, including the indications and contraindications
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Equipment: List any new equipment required or indicate “Not Applicable”
____________________________________________________________________________________________

Additional Resources: List additional resources required or indicate “Not Applicable”
____________________________________________________________________________________________

Staff Training: List any training needed for clinic staff
____________________________________________________________________________________________

Date procedure/service is to be implemented: ____________________________________

Requestors Signatures:

Physician: _______________________________________________________________ Date: _______________

Medical Director/Chair: ____________________________________________________ Date: _______________

Department Administrator: _________________________________________________ Date: _______________

Approvers Signatures:

Director of Nursing: _________________________________________________________ Date: _______________

Office of Claims Management: ________________________________________ Date: _______________

Office of Medical Staff: ______________________________________________ Date: _______________

Office of Quality Improvement: ______________________________________ Date: _______________

Coding Department: ______________________________________________ Date: _______________

MPIP Office: ______________________________________________________ Date: _______________