



McGovern
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Research Imaging Services: Professional Read Pricing Request

Date:
PI:
Department:
Billing Contact:
Billing Contact Email:
Billing Contact Phone:

Study Information

Title:
Sponsor name:
Sponsor Type: <input type="checkbox"/> Federal <input type="checkbox"/> Industry <input type="checkbox"/> Other (specify):
EG Institutional Account Number:
CPHS Protocol #:
NCT #:

Est. Start Date:
Est. End Date:
Est. # of Patients:
Imaging Location(s):

Non-SOC Imaging/Procedures requested for the study:

<i>Imaging Procedure</i>	<i>CPT Code</i>

Signature of PI/Representative: _____

Date:

Signature of DII Representative: _____

Date: