STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Request For Authorization for Coverage of Routine Patient Care Costs Associated with Clinical Trials

Section I

Date: _____

Member name:_____

Member ID #:_____

Member Date of Birth:_____

Health Insurer:_____

Treating Physician:_____

Contact Person for Additional Information Regarding Member's Treatment:

Name: _____

Address:_____

Phone number: _____

Fax number: _____

E-mail address: _____

Service requested is: ____ Outpatient ____ Inpatient ___Office Setting

If outpatient or inpatient is checked:

Facility name & address:_____

Clinical Cooperative Group Number:_____ (Please provide Web site address or other reference for accessing information about this trial.)

Please Note: You may be asked to provide additional information about the clinical trial or the member's diagnosis and condition prior to the authorization of this request.

If the clinical cooperative group number is provided above, you do not need to complete Section II.

Section II must be completed only if the Clinical Cooperative Group Number is unavailable.

Section II

Diagnosis code:_____

Proposed treatment protocol:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Phase of clinical trial: ____ I ____ II ____ III

Sponsor of clinical trial:_____

Clinical Trial has been reviewed and approved by:

____ National Institutes of Health
____ National Cancer Institute
____ Federal Food and Drug Administration
____ Federal Dept. of Defense
____ Federal Dept. of Veterans Affairs
____ Medicare Clinical Trial Policy

Check one: ____ Single center study ____ Multiple center study

List name(s) and address(es) of center(s):

_____
_____
_____
_____
_____