

Aurora Health Care, Milwaukee, Wisconsin	MRU # _____
<input type="checkbox"/> Aurora Sinai Medical Center	Patient Name: _____
<input type="checkbox"/> St. Luke's Medical Center	DOB: _____
<input type="checkbox"/> West Allis Medical Center	Case #: _____
<input type="checkbox"/> St. Luke's South Shore	Date Enrolled: _____
	Date Study Completed: _____
<input type="checkbox"/> Other _____	

Sponsor Name: _____	IRB #: _____
Protocol Name: _____	
Protocol #: _____	IND #: _____
IDE #: _____	
Principal Investigator: _____	Phone: _____
Sub-Investigator: _____	Phone: _____
Study Coordinator: _____	Phone: _____
	Fax: _____

Type of Service:	<input type="checkbox"/> Radiology	<input type="checkbox"/> Lab	<input type="checkbox"/> Pathology	<input type="checkbox"/> Other _____
Date: _____	Services Provided: _____			
_____	_____			
_____	_____			
_____	_____			

Cost Center # 05- _____
Invoice (Check one) <input type="checkbox"/> Clinical Research Cost Center or <input type="checkbox"/> Investigator
Check as Appropriate: <input type="checkbox"/> No Discounts Apply
<input type="checkbox"/> Discounts Apply per Attached Discount Approval
<input type="checkbox"/> Discount Approval Letter on File

NOTE:			
If inpatient, complete the Clinical Trials Progress Note and place in patients chart.			
If outpatient and services involve Aurora Health Care facilities, Email this Clinical Trials Billing Form to the appropriate medical records department and any other department(s).			
Email to: (check as appropriate)			
<input type="checkbox"/> AHC Billing	<input type="checkbox"/> Labs	<input type="checkbox"/> Pathology Billing	<input type="checkbox"/> Radiology
<input type="checkbox"/> AMG Billing	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Radiology Billing	<input type="checkbox"/> Other

Clinical Trials Billing Form

Keep As Permanent