UNIVERSITY HOSPITAL VALUE ANALYSIS PROGRAM

Value Analysis Core Group **SUNY Upstate Medical University**

Please print or type

Section I Coordinators Final Review Summary

A. Financial Impact: _____
_____
_____
_____

B. Clinical Findings: _____
_____
_____
_____

C. Reimbursement Impact: _____
_____
_____

D. Other Considerations: _____
_____
_____
_____
_____

E. Recommendations: _____
_____
_____
_____
_____

Coordinator Signature: _____ Date: _____

Section II Value Analysis Core Group Action

Approve / Request additional information / Sub-Group recommends product (s) are not acceptable
Defer project at this time

Section III Implementation Plan

1) MMOT recommendation. Date submitted to MMOT:_____
Date MMOT makes recommendation: _____
2) ECC recommendation. Date TA Forms submitted to ECC: _____

Value Analysis Coordinator Signature: _____ Date: _____

***Memo to Requestor with outcome of clinical trial and VAP Core Group recommendation**