THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Clinical Trial Patient Payment Request

*Required

STUDY INFORMATION *(TO BE COMPLETED BY CCRM RESEARCH BUDGET ANALYST)*

***Study Group** ***Study Name** ***PI** ***Grant #**

If OSP Grant # will not be assigned, provide department Worktags:

PARTICIPANT INFORMATION *(TO BE COMPLETED BY COORDINATOR)*

Subject Name** ***Subject ID** ***Date of Birth *(MM/DD/YYYY)

***Address** ***City, State & Zip**

***Confirm if there has been a change to patient's address since their last visit:** Yes No

***If yes, complete a new Substitute W-9 (Vendor Form) & list previous address below:**

VISIT INFORMATION *(TO BE COMPLETED BY COORDINATOR)*

***Visit Description:**
(Per study summary)

***Date(s) of Service:**

***Location:** Main Campus OCE MMP Gahanna East Hospital
Completed Remotely Other *(please specify)*:

ClinCard Request Check Request

ClinCard # *(16 digits)*:

This is a replacement card: Yes No

New Card Token #:

Stipend: Meals/Per Diem:

Mileage: X X Total Mileage Reimbursement:
*Miles round trip^* *Mileage Rate†* *# of Visits*

Contracted mileage rate: Set rate Federal Rate

Fixed Mileage Amount:

Gift Card Distribution

Card #:

Vendor:

Amount:

Total Payment Amount:
(Automatically calculated)

Coordinator Name *(first and last)*:
When form is completed, print and obtain signatures.

Coordinator Signature: **Date:**

Patient Signature: **Date:**

^Mileage map showing total miles is required
†Current federal mileage rate can be found HERE
The current Vendor Setup Form can be found HERE