Request for New Product

Vendor Product Information
Vendor to complete and return to Hospital designee for this product; Products will not be presented to VAT Teams without this form completed in its entirety.

VENDOR INFORMATION

Company Name:

Sales Rep:

Are you a Diverse Vendor?

SALES REP CONTACT INFORMATION

Cell Phone Number:

Office Phone Number:

E-mail:

Are you currenty a Certified Rep with Henry Ford Health System?
Yes No

PRODUCT INFORMATION

Manufacturer:

Distributor:

Item Description:

Item Catalog #:

Does this product contain latex? Yes No

Is this item ferromagnetic? Yes No

Copy of 510(k) Approval Attached? Yes No

Is this item on a Premier Contract? Yes No

PRODUCT FEATURES

Indications for use:

Clinical Outcome: *Evidence Based Study; not sponsored by vendor*

Product Advantages:

Any impact to Length of Stay (LOS):

Any impact to Length of Procedure:

PROCUREMENT INFORMATION

Shipping unit of measure (U/M):

Quantity per U/M:

Product Purchased Direct or through a Distributor:

Henry Ford Health System Price:

Availability:

If item is not available due to backorder, is there a substitute product replacement? Yes No

REIMBURSEMENT INFORMATION

What HCPCS code applies to this product?

What CPT code applies to this product?

COMPETITIVE MARKET INFORMATION

What are the perceived competitive products for this product?