UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER

Bulk Account Application for Hospital Billed Charges

Research

Bulk Account Number: _____

*BULK ACCOUNT TITLE: (Maximum of 20 Characters)

___/

BULK ACCOUNT NUMBER: _____

*TITLE OF GRANT: _____

_____

_____

*PRINCIPAL INVESTIGATOR: _____

*GRANT DURATION: _____

*ESTIMATED VOLUME OF SERVICE: Number of Patients: _____

*TYPE OF SERVICE: INPATIENT ☐ OUTPATIENT ☐

*CLINICAL TRIAL COORDINATOR: Name: _____Ext.: _____

*DEPARTMENT AND MAILING ADDRESS: _____

*ACCOUNT MANAGER: Name: _____Ext.: _____

*DEPARTMENT AND MAILING ADDRESS: _____

*MONTHLY CLEARING: _____/_____
DaFIS Account Number Object Code

*PREPARED BY: _____ DATE: _____

*REVIEWED BY: _____ DATE: _____
Principal Investigator

*REVIEWED BY: _____ DATE: _____
Department Manager

REVIEWED BY: _____ DATE: _____
Patient Accounts Analysis

***MUST BE COMPLETED.**

NOTE: Return ALL to: Patient Accounts Analysis, Broadway Bldg., Suite 2130, or by FAX 4-9185.

Revised 9/3/97