UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Client Services Fax: 319-384-7213
Billing Fax: 319-356-0729

ELECTRON MICROSCOPY REQUISITION

RESET

FOR UIDL USE ONLY: MRN# PATH#

FOR CLIENT USE ONLY: Requisition Date Completed by:

PART A – PATIENT INFORMATION – *Required*			**PART B – PROVIDER INFORMATION – *Required***		
Patient Last Name:			Referring Institution:		
Patient First Name:			Street:		
Street:			City:	St:	Zip:
City:	St:	Zip:	Phone:	Fax:	
Phone:	Fax:		**Referring Physician:**		
Date of Birth:	Gender: ☐ M ☐ F		**Referring Physician Phone:**		

PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)

To meet TAT expectations and to provide timely patient results, please send all material FED EX FIRST OVERNIGHT.

MATERIALS SUBMITTED: _____ **SLIDES*** _____ **BLOCKS*** _____ **WET TISSUE** _____ **OTHER** Specify source below

Required ICD-10 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

TISSUE SOURCE/SITE: _____ **DATE OF COLLECTION:** _____

TESTING REQUESTED:

For Muscle or Nerve Tissue

☐ Technical with Pathologist Interpretation

For Renal Tissue

☐ Technical Only

☐ Technical with Pathologist Interpretation

_____ _____

Physician Signature **Date**

PERTINENT CLINICAL HISTORY AND FINDINGS: _____

_____

CLINICAL DIFFERENTIAL DIAGNOSIS: _____

_____

PREVIOUS TESTS RELEVANT TO CURRENT PROBLEM: _____

PART D – SEND BILL TO: ☐ **Referring Institution- Include email for invoicing:**

☐ **Patient's Insurance** **(No Medicaid accepted other than IA - those cases will be considered to be Self Pay)**

☐ **Self Pay IA Resident** **(UIDL will direct bill)** ☐ **Self Pay Non Iowa Resident** **(Requires Prepayment)**

NOTE: The UIDL will balance bill patients directly for residual deductibles/copays after insurance adjudication.

On date of collection, was patient: **Admission Date:** _____ **Discharge Date:** _____

☐ **Inpatient** ☐ **Outpatient** ☐ **Non-Hospital Patient - Facility name where specimen collected:** _____

Primary Insurance Coverage Information			**Secondary Insurance Coverage Information**		
Insured by:			Insured by:		
Claims Address:			Claims Address:		
City:	St:	Zip:	City:	St:	Zip:
Policy/ID #:	Group #:		Policy/ID #:	Group #:	
Name of Subscriber:		DOB:	Name of Subscriber:		DOB:
Relationship to Patient:			Relationship to Patient:		

Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage, OR

(2) a printout with patient demographics and insurance information from your practice management system.

REQUIRED: FAX requisition form, billing information and history form, PRIOR to shipping to (319) 384-7213.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for UIDL Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens. *4/28/2025 CG*

PRINT