

LABORATORY REQUISITION

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

FOR CLIENT USE ONLY: Requisition Date: _____ Completed By: _____ Accn# _____
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FOR UIDL USE ONLY: UIDL Accn # _____ UIDL MRN# _____
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PART A - PATIENT INFORMATION - <i>Required</i>			
Patient Name: _____			
Street: _____			
City: _____	St: _____	Zip: _____	
Phone: _____			
Date of Birth: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

PART B - PROVIDER INFORMATION - <i>Required</i>			
Referring Institution: _____			
Street: _____			
City: _____	St: _____	Zip: _____	
Phone: _____	Fax: _____		
Referring Physician: _____			
Referring Physician NPI: _____			

PART C) SPECIMEN INFORMATION - <i>Required</i>		
Date Collected: ____/____/____	Time: _____	Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood <input type="checkbox"/> Random Urine <input type="checkbox"/> 24 hr. Urine –volume: _____ <input type="checkbox"/> Other (specify): _____

Required ICD-9 codes: 1. _____ 2. _____ 3. _____ 4. _____
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TEST(S) REQUESTED: (Please include or attach any additional information such as specimen specifics or pertinent clinical history)	

REFER TO UIDL [TEST DIRECTORY](#) FOR SPECIMEN REQUIREMENTS AND HANDLING INSTRUCTIONS

PART D - SEND BILL TO: (Required)

Referring Institution Contact Person: _____
 Address: _____
 City, State, Zip _____
 Phone: _____ Fax: _____ E-mail: _____

Patient's Insurance (Complete billing information must be provided or referring institution may be billed)
(Required information is in red)

Primary Insurance Coverage Information

Insured by: _____
 Claims Address: _____
 City: _____ ST: _____ ZIP: _____
 Policy/ID #: _____ Group #: _____
 Name of Subscriber: _____ DOB: _____
 Relationship to Patient: _____

Secondary Insurance Coverage Information

Insured by: _____
 Claims Address: _____
 City: _____ ST: _____ Zip: _____
 Policy/ID #: _____ Group #: _____
 Name of Subscriber: _____ DOB: _____
 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.

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.