U I D L
UI Diagnostic Laboratories

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

LABORATORY 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 - ***REQUIRED***

DATE OF COLLECTION: _____ **TIME OF COLLECTION:** _____
Required ICD-10 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Specimen Type: ☐ Serum ☐ Plasma ☐ Whole Blood ☐ Random Urine ☐ 24 hr. Urine –volume: _____
☐ Other (specify): _____

TEST(S) REQUESTED

☐ Alanine Aminotransferase (ALT) [LAB132]	☐ Rubella Antibody, IgG [LAB4835]
☐ Aspartate Aminotransferase (AST) [LAB131]	☐ Tacrolimus [LAB908]
☐ CBC with Automated Differential [LAB293]	☐ Thyroid Stimulating Hormone (TSH) [LAB129]
☐ Cholesterol, High-Density Lipoprotein [LAB101]	☐ Triglycerides [LAB134]
☐ Comprehensive Metabolic Panel [LAB17]	
☐ Creatinine [LAB66]	*Other:*
☐ Glucose [LAB82]	☐
☐ Hemoglobin [LAB291]	☐
☐ Hemoglobin A1C [LAB90]	☐
☐ Hepatitis C Virus Antibody [LAB627]	☐
☐ HIV Antigen/Antibody Combo (HIV-1 & HIV-2) [LAB7444]	☐
☐ Immunoglobulin A (IgA), Individual Quant [LAB73]	☐
☐ Immunoglobulin E (IgE), Individual Quant [LAB74]	☐
☐ Immunoglobulin G (IgG), Individual Quant [LAB71]	☐
☐ Immunoglobulin M (IgM), Individual Quant [LAB72]	☐ Anti-Nuclear Antibody Screen and Reflex Titer [LAB1256] - Immunology
☐ Lipid Panel [LAB18]	☐ Anti-Neutrophil Cytoplasmic (ANCA) Screen [LAB1327] - Immunology
☐ Measles Antibody, IgG [LAB2404]	☐ UC-ANCA Screen and Interpretation [LAB1365] - Immunology

PART D – BILLING – REQUIRED **NOTE: Claims can't be submitted to a Medicaid or BCBS Program Outside of Iowa**

On date of collection, was patient: **Admission Date:** _____ **Discharge Date:** _____
☐ **Inpatient** ☐ **Outpatient** ☐ **Non-Hospital Patient - Facility name where specimen collected:** _____

☐ **Bill Client**
Email Recipient for Invoicing _____
Name: _____ **Phone:** _____

☐ **Bill Insurance** **PRE-AUTHORIZATION #:** _____ Client will be responsible for all charges if required Pre-Authorization is not provided as needed.

See website for a comprehensive guide to UIDL Billing - https://uidl.medicine.uiowa.edu/billing

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:		

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