UIDL
UI Diagnostic Laboratories

MUSCLE & NERVE BIOPSY REQUISITION

RESET

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

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*
SPECIFY FROZEN BIOPSY (ship on dry ice, refer to the UIDL TEST DIRECTORY for specimen requirements.)
☐ Muscle (routine evaluation)
☐ Muscle (muscular dystrophy evaluation: DMD, BMD, LGMD, CMD, Emery-Dreifuss)
☐ Skin (Emery-Dreifuss or merosin-deficient CMD)
☐ Nerve (epon sections and teased fiber preparation)
Describe**:** _____
Biopsy Date: _____ **Biopsy Site:** _____
Required ICD-10 codes: 1. _____ 2. _____

SEND SAMPLES TO:
Dr. Steven A. Moore
The University of Iowa Hospitals and Clinics
Department of Pathology, 5231 RCP
200 Hawkins Drive
Iowa City, IA 52242
Office Phone: (319) 384-9084
Fax: (319) 384-8053
Email: steven-moore@uiowa.edu

UIDL Client Services: (866)844-2522

TESTS RELEVANT TO CURRENT PROBLEM: CK _____ EMG _____
Other: _____

CLINICAL DIAGNOSIS:

CLINICAL HISTORY & FINDINGS / FAMILY HISTORY (continue on back of form if necessary):

ADDITIONAL CONTACT INFORMATION

PATIENT'S PHYSICIAN			**REFERRING PATHOLOGIST**		
Name:			Name:		
Address:			Address:		
City:	St:	Zip:	City:	St:	Zip:
Phone:	Fax:		Phone:	Fax:	
Email:			Email:		

PART D – BILLING – REQUIRED
NOTE: Claims can't be submitted to a Medicaid 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 #:** _____ Required for all out of state cases.
☐ **Self Pay Iowa Resident - UIDL will invoice**
☐ **Self Pay Non Iowa Resident - Prepayment Required**
See website for a comprehensive guide to UIDL Billing and prepayment requirements - 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 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.

PRINT

4/28/2025 CLG