

MUSCULAR DYSTROPHY BIOPSY 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 Case # _____ UIDL MRN# _____
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PART A - PATIENT INFORMATION - Required		
Patient Name: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____		
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

PART B - PROVIDER INFORMATION - Required		
Referring Institution: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____	Fax: () _____	
Referring Physician: _____		
Referring Physician NPI: _____		

PART C – SPECIMEN INFORMATION - Required SPECIFY FROZEN BIOPSY (ship on dry ice, refer to the UIDL TEST DIRECTORY for specimen requirements.) <input type="checkbox"/> Muscle (Duchenne, Becker, LGMD, CMD, Emery-Dreifuss) <input type="checkbox"/> Skin (Emery-Dreifuss or CMD) <input type="checkbox"/> Other Site (Emery-Dreifuss only) Describe: _____ Biopsy Date: _____ Biopsy Site: _____
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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 E-mail: steven-moore@uiowa.edu
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TESTS RELEVANT TO CURRENT PROBLEM: CK _____ EMG _____ Other: _____
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CLINICAL DIAGNOSIS: _____

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

ADDITIONAL CONTACT INFORMATION	
<u>PATIENT'S PHYSICIAN</u> Name: _____ Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____ E-mail: _____	<u>REFERRING PATHOLOGIST</u> Name: _____ Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____ E-mail: _____

PART D - SEND BILL TO: (Required)	<input type="checkbox"/> Referring Institution Contact Person: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ E-mail: _____ <input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed) <i>(Required information is in red)</i>
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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.

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.