UIDL
UI Diagnostic Laboratories

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

LIVER BIOPSY REQUISITION

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.)

MATERIALS SUBMITTED: ____ WET TISSUE ____ SLIDES ____ BLOCKS ____ OTHER, Specify source _____

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

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

LIVER BIOPSY CONSULTATION REQUESTED: (Please include/attach a list of diagnoses of prior biopsies and the most recent biopsy, if possible)

☐ **Routine Consultation**	☐ **STAT Post Transplant**
TAT: 3-5 days M-F	TAT: 24 hrs Mon-Sat -- WEEKEND STATS-Provide notification, call 1-866-844-2522 by 7:30 PM Friday or by 1:00 PM on Saturday (CST)
Report: Fax	Preliminary Report: Called by pathologist Final Report to follow via fax

TRANSPLANT? ☐ YES ☐ NO **If Yes, diagnosis at time of transplant?** _____

PERTINENT CLINICAL HISTORY AND FINDINGS: (please include recent labs (AST, ALT, GGT, Alkaline Phosphatase, etc))

_____

_____

CLINICAL DIFFERENTIAL DIAGNOSIS: _____

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.

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

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 information from your practice management system.

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.

PRINT

4/28/2025 CLG