UIDL
UI Diagnostic Laboratories

Toll-free: 866-844-2522
Local: 319-384-7212

RESET

Transplant Pancreas Pathology Requisition

FEDEX TRACKING #: _____
Contact Phone: _____

FAX THIS FORM TO: 319-384-7213

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:		

CLINICIAN TO CALL WITH BIOPSY RESULTS – *Required*		
Ordering Clinician Name:		
Clinician Cell:	Office:	Fax:
Group Name:		
Address:		
City:	State:	Zip:

PART C - SPECIMEN INFORMATION – *Required*

DATE OF TRANSPLANT: _____ **TYPE OF TRANSPLANT** ☐ **Pancreas only** ☐ **Other:** _____

SHIPPING: ☐ **FedEx Overnight** ☐ **FedEx SATURDAY Delivery*** ☐ **CDS Courier** ☐ **Other:** _____

***Friday shipments - Call IMMEDIATELY to notify the weekend staff** 1-866-844-2522 (M-F 7:30 AM – 7:30 PM)

Please check all testing you are requesting - Pancreas: ☐ **LM** ☐ **LM + C4d** ☐ **EBV** ☐ **CMV**

C4d Testing on the Weekend:
If the biopsy is on Friday and the specimen is a STAT to be read on Saturday with the need for C4d on Saturday, then a small portion of tissue should also be sent in Michel's media for C4d immunofluorescence.

SPECIAL INSTRUCTIONS: _____

Specimen Source: ☐ **Transplant Pancreas** ☐ **Other** **Collection Date:** ____/____/____

Specimen(s): ☐ **Formalin Vial** ☐ **Other transport media (_____)** ☐ **Slides** ☐ **Paraffin Block**

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

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

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

CLG 5/5/2025