

Transplant Pancreas Pathology Requisition

FEDEX TRACKING #: _____
Contact Phone: _____

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

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 – <i>Required</i>	PART B – PROVIDER INFORMATION – <i>Required</i>
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: <input type="checkbox"/> M <input type="checkbox"/> F	Referring Physician Phone: _____

CLINICIAN TO CALL WITH BIOPSY RESULTS – <i>Required</i>
Ordering Clinician Name: _____
Clinician Cell: _____ Office: _____ Fax: _____
Group Name: _____
Address: _____
City: _____ State: _____ Zip: _____

PART C - SPECIMEN INFORMATION – <i>Required</i>
DATE OF TRANSPLANT: _____ TYPE OF TRANSPLANT <input type="checkbox"/> Pancreas only <input type="checkbox"/> Other: _____
SHIPPING: <input type="checkbox"/> FedEx Overnight <input type="checkbox"/> FedEx SATURDAY Delivery* <input type="checkbox"/> CDS Courier <input type="checkbox"/> 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: <input type="checkbox"/> Transplant Pancreas <input type="checkbox"/> Other _____ Collection Date: ____/____/____
Specimen(s): <input type="checkbox"/> Formalin Vial <input type="checkbox"/> Other transport media (_____) <input type="checkbox"/> Slides <input type="checkbox"/> 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: _____
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient - Facility name where specimen collected: _____	
<input type="checkbox"/> Bill Client	
Email Recipient for Invoicing _____	
Name: _____ Phone: _____	
<input type="checkbox"/> Bill Insurance PRE-AUTHORIZATION #: _____ Required for all out of state cases.	
See website for a comprehensive guide to UIDL Billing - https://medicine.uiowa.edu/uidl/resources/billing-options	
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.*