

LIVER BIOPSY REQUISITION

UIDL Client Code: _____	Accession/Case: _____
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FOR CLIENT USE ONLY: Requisition Date _____	Completed by: _____
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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: _____

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.)

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: _____