U I D L
UI Diagnostic Laboratories

DeGowin Blood Center Requisition

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

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 AND PATIENT HISTORY- *Required*

Date Collected: ____/____/____ **Time:** _____ **Specimen Type:** ☐ **EDTA Whole Blood** ☐ **Other, Specify:** _____

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

Does the patient have a history of transfusion? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown If yes – Estimated Gestation:

Does the patient have a history of red cell antibodies? ☐ Yes ☐ No ☐ Unknown If yes – Antibody(ies):

Has the patient received Rh(D) in the past three months? ☐ Yes ☐ No ☐ Unknown

Has the patient received IVIG in the past three months? ☐ Yes ☐ No ☐ Unknown

SELECT TEST: Refer to the **UIDL TEST DIRECTORY** for specimen requirements and CPT Codes at https://www.healthcare.uiowa.edu/path_handbook/rindex.html

☐ Blood Type (ABO and Rh) [LAB4309]
☐ Antibody Identification & Clinical Pathology Consultation [LAB4325] (Note: Antibody Identification may require extensive testing necessary to interpret antibody
☐ Antibody Screen [LAB4402]
☐ Antibody Titration (IgM + IgG) [LAB4326], Specify Antibody:
☐ Direct Antiglobulin Test (DAT) [LAB5548]
☐ Fetal Bleed Screen [LAB4367]
☐ Platelet Antibody Screen and Clinical Pathology Consultation [LAB4388]
☐ RBC Antigen Testing [LAB4384], Specify Antigen:
☐ Reverse Type only (ABO) [LAB4312]
☐ Other (Specify):

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://www.healthcare.uiowa.edu/uidl/site/billing_services/index.html

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), OR (2) a printout with patient demographics and insurance information from your practice management system. Please designate primary vs. secondary/tertiary coverage.

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

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