U I D L
UI Diagnostic Laboratories

FEDEX TRACKING #: _____

FAX THIS FORM TO: (319) 384-7213

200 Hawkins Drive, 5231 RCP
TOLL-FREE: (866) 844-2522
LOCAL: (319) 384-7212

Renal Pathology Requisition

RESET

FOR UIDL USE ONLY: MRN# PATH#

FOR CLIENT USE ONLY: Requisition Date Completed by:

SPECIMEN INFORMATION *REQUIRED*

STATUS: ☐ STAT ☐ ROUTINE **Has the patient had a RENAL TRANSPLANT?** ☐ Yes ☐ No **If Yes, when?** _____

Please check all testing you are requesting: ☐ LM, IF, + EM ☐ IF & EM ☐ EM only ☐ C4d ☐ BK Virus

SPECIAL INSTRUCTIONS:

Specimen Source: ☐ Left Kidney ☐ Right Kidney **Collection Date:** / / ☐ Outpatient ☐ Inpatient

Specimen(s): ☐ Formalin Vial ☐ Michel's Vial ☐ Glutaraldehyde Vial ☐ Slides ☐ Paraffin Block

Required ICD-10 Code(s): 1) 2) 3) 4)

PATIENT INFORMATION please print

Legal Last Name:

Legal First Name: DOB: Male ☐ Female ☐

Address:

City: State: Zip:

Phone:

NEPHROLOGIST TO CALL WITH BIOPSY RESULTS *REQUIRED*

Ordering Nephrologist Name:

Nephrologist Cell: **Office:** **FAX:**

Group Name:

Address:

City: **State:** **Zip:**

REFERRING INSTITUTION OR PATHOLOGY GROUP

Institution/Path Group Name:

Pathologist Name:

Phone: **FAX:**

Address:

City: **State:** **Zip:**

INSURANCE INFORMATION REQUIRED

NOTE: Claims can't be submitted to Medicaid Program Outside of Iowa. Out of state Medicaid cases will be considered to be Self Pay cases.

On date of collection, was patient: **Admission Date:** _____ **Discharge Date:** _____

☐ **Inpatient** ☐ **Outpatient** ☐ **Non-Hospital Patient - Facility name where specimen collected:** _____

☐ **Bill Client** ☐ **Self Pay IA Resident (UIDL will direct bill)** ☐ **Self Pay Non Iowa Resident - Requires Prepayment**

Email Recipient for Invoicing Client Directly:

Name: _____ **Phone:** _____

☐ **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/sending-case/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 specimen.

PRINT