UIDL
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

**REQUIRED** **on the day this case is being sent:** Email ***UIDLClientServices@healthcare.uiowa.edu*** **a copy of this requisition and all billing. Same information must be in box with specimen upon arrival to the UIDL, as well.**

# Renal Pathology Requisition

PRINT 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: / /**

**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://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.*

4/28/2025 CLG