TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-1B Specimen Submission Form (SEP 2014)
CAP# 3024401 CLIA #45D0660644
Laboratory Services Section, MC-1947
P. O. Box 149347, Austin, Texas 78714-9347
Courier: 1100 W. 49th Street, Austin, Texas 78756
(888) 963-7111 x7318 or (512) 776-7318
http://www.dshs.state.tx.us/lab

****For DSHS Use Only****
Place DSHS Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (** REQUIRED)

Submitter/TPI Number **	Submitter Name **
**NPI Number **	Address **
City **	State ** / Zip Code **
Phone **	Contact
Fax **	Clinic Code

Section 2. PATIENT INFORMATION -- (** REQUIRED)

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name **	First Name **	MI
Address **	Telephone Number	
City **	State ** / Zip Code **	Country of Origin
**DOB (mm/dd/yyyy) ** **	Sex ** / SSN	Pregnant? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Date of Collection ** (REQUIRED)	Time of Collection ☐ AM ☐ PM	Collected By
Medical Record Number	Alien # / CUI / CDC ID	Previous DSHS Specimen Lab Number
ICD Diagnosis Code ** (1)	ICD Diagnosis Code ** (2)	ICD Diagnosis Code ** (3)

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Date of Onset (mm/dd/yyyy)	Diagnosis / Symptoms	Risk

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Venous ☐ Serum
☐ Blood: Filter Paper ☐ Plasma ☐ Other:

Section 4. CHEMISTRIES

☐ **Cholesterol ▲**
☐ **High-density lipoprotein (HDL) ▲**
☐ **Lipid panel ▲**
(includes cholesterol, triglycerides, HDL, and low-density lipoprotein (LDL))

Diabetes:
☐ **Glucose, Random ▲**
☐ **Glucose, Fasting ▲**
☐ **Glucose, 1 Hour ▲**
☐ **Glucose, 2 Hour Post prandial ▲**
☐ **Glucose Tolerance, 1 Hour ▲**
☐ **Glucose Tolerance, 2 Hour ▲**
☐ **Glucose Tolerance, 3 Hour ▲**

__ __.__ **hrs.** Time since last meal

Section 5. HL

☐ **Hemoglobin (Hb)**
☐ **Lead**
If this is a follow-up due to a previous abnormal or elevated result, mark "Yes" below and provide previous DSHS specimen lab number in Section 2.
☐ Yes

Section 6. Hb TYPES

☐ **Hemoglobin electrophoresis**
(Accepted on Snap-Apart Card only)

Section 7. PKU DIETARY MONITORING

☐ **Phenylalanine / Tyrosine**
(Does not include full NBS panel)

Section 8. ORDERING PHYSICIAN INFORMATION -- (** REQUIRED)

**Ordering Physician's NPI Number ** **	Ordering Physician's Name **

Section 9. PAYOR SOURCE -- (REQUIRED)

1. **Reflex testing** will be performed when necessary and the appropriate party will be billed.
2. If the patient does not meet program eligibility requirements for the test requested and no third party payor will cover the testing, **the submitter will be billed**.
3. Medicare generally does not pay for screening tests-please refer to applicable Third party payor guidelines for instructions regarding covered tests, benefit limitations, medical necessity determinations and Advanced Beneficiary Notice (ABN) requirements.
4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. Please **write** it in the space provided below.
5. If private insurance is indicated, the required billing information below is designated with an asterisk (*).
6. **Check only one box** below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program.

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

☐ Submitter (3) ☐ Private Insurance (4)
☐ BIDS (1720) ☐ Title X (12)
☐ BT Grant (1719) ☐ Title XX (13)
☐ HIV / STD (1608) ☐ TX CLPPP (9)
☐ Immunizations (1609) ☐ Zoonosis (1620)
☐ Refugee (7) ☐ Other: _____
☐ TB Elimination (1619)

HMO / Managed Care / Insurance Company Name *	
Address *	
City * / State * / Zip Code *	
Responsible Party (Last Name, First Name) *	
Insurance Phone Number *	Responsible Party's Insurance ID Number *
Group Name	Group Number

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 10. DNA ANALYSIS +++ Preauthorization required +++

☐ **Galactosemia: Common Mutation Panel**
☐ **Cystic Fibrosis: Mutation Panel**
☐ **MCAD: Mutation Panel**

Hemoglobin DNA Test:
☐ **Hb S, C, E, D, or O-Arab**
☐ **Common Beta-Thalassemia Mutation**
☐ **Beta-Globin Gene Sequencing**

Clinical diagnosis:

NOTES: All dates must be entered in mm/dd/yyyy format.
▲ = Document **time & date** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.
Please see the form's instructions for details on how to complete this form.
Details of test and specimen requirements can be found in the Laboratory Services Section Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

▲ REQUIRED for cold shipments. Indicate REMOVAL from:
☐ **FREEZER** ☐ **REFRIGERATOR**

DATE (mm/dd/yyyy)	**TIME** ☐ AM ☐ PM

FOR LABORATORY USE ONLY Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

Biochemistry and Genetics

G-1B Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany ***each*** specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

Place DSHS Bar Code Label Here: If you are performing remote entry, place DSHS LIMS specimen bar code label here. Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system (LIMS).

Section 1. SUBMITTER INFORMATION

All submitter information that is required is marked with double asterisks (**).

Submitter/TPI Number, Submitter Name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. To request a DSHS Laboratory Services Section submitter number, a master form, or to update submitter information, please call (888) 963-7111 x7578 or (512) 776-7578, or fax (512) 776-7533, or visit http://www.dshs.state.tx.us/lab/mrs_forms.shtm#email. For THSteps submitters: To obtain a Texas Provider Identifier (TPI) number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

NPI Number: Indicate the facility's 10-digit National Provider Identifier (NPI) number. All health care providers must use the National Provider Identifier (NPI) number. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a legible photocopy of a master form provided by the Laboratory Services Section. **Do not use any specimen submission forms with "SAMPLE" watermarked on it**. For updates or changes, please contact Lab Reporting at (512) 776-7578.

Contact Information: Indicate the name, telephone number, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race, ethnicity, date of birth (DOB), sex, social security number (SSN), pregnant, date of collection, time of collection, medical record number, alien #/CUI, ICD diagnosis code, and previous DSHS specimen lab number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). These fields must be completed. You may use a pre-printed patient label as long as the patient's first and last names are clearly identified as such.

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form and specimen must match the name on the Medicaid, Medicare, and insurance card, respectively.

Date of birth (DOB): List the date of birth. If date of birth is not provided or is inaccurate, specimen may be rejected.

Pregnant: Indicate if female patient is pregnant by marking either Yes, No, or Unknown.

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient. Do not give the date the specimen was sent to DSHS. **IMPORTANT: If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.**

Collected By: Clearly indicate the individual who collected the specimen.

Medical Record Number / Alien# / CUI: Provide the identification number for matching purposes. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS specimen lab number.

ICD Diagnosis Code(s): Indicate the diagnosis code(s) that would help in processing, identifying, and billing of this specimen.

Section 3. SPECIMEN TYPE

Specimen Type: Indicate the type of specimen that is being submitted.

Section 4. CHEMISTRIES

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Lipid Profile, Cholesterol, HDL, and Glucose: Serum/plasma specimens must be frozen. *The time and date the specimen is removed from FREEZER **must** be provided to determine specimen acceptability. Please mark FREEZER.*

Section 5. HL

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Section 6. Hb Types

Test Requested: Mark the specific test(s) to be performed by the Laboratory Services Section. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Section 7. PKU DIETARY MONITORING

Test Requested: Check the Phenylalanine/Tyrosine test to be performed by the Laboratory Services Section. Please NOTE: This test only includes measurement of phenylalanine and tyrosine and does not include the full Newborn Screening panel of tests. This does not satisfy the NBS requirement for a second screening. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Section 8. PHYSICIAN INFORMATION

Ordering Physician's name and NPI Number: Give the name of the physician and the physician's NPI number. **This information is required to bill Medicaid, Medicare, and insurance.**

Section 9. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided, is inaccurate, or multiple payor boxes are checked.

Indicate the party that will receive the bill by marking only one box.

Please do not use this form for THSteps medical check-ups; use the G-THSTEPS form.

If selecting Medicaid or Medicare:
- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the Medicaid/Medicare card, the submitter will be billed.
- Patient's DOB and address must be provided.

If selecting Private Insurance:
- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (*).
- If the insurance information is not provided on the specimen form or is inaccurate, the submitter will be billed.
- Patient's DOB and address must be provided.

If selecting DSHS Program:
- If you are contracting and/or approved by a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/prog_desc.htm.
- **Do NOT check a DSHS program as a Payor Source if the patient has Medicaid, Medicare, or private insurance.**
- For BIDS (Border & Infectious Disease Surveillance), CLPPP or IDEAS, check the appropriate box. Please check the "Other" box and list the program's name in the space provided if necessary.

HMO / Managed Care / Insurance Company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed. NOTE: The DSHS laboratories are not an in-network CHIP or CHIP Perinate provider. If CHIP or CHIP Perinate is indicated, the submitter will be billed.

Responsible Party: Print the Last Name, First Name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

Section 10. DNA ANALYSIS

Select the requested test and provide clinical diagnosis, if available. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial. The genes analyzed are β-Globin for hemoglobin testing, galactose-1-phosphate uridyl transferase for galactosemia testing, cystic fibrosis transmembrane conductance for cystic fibrosis testing, and medium-chain acyl-CoA dehydrogenase for MCAD mutation panel testing.

For all hemoglobin DNA tests, select the box. Available tests include:

- Hb S, C, E, D, or O-Arab
- Common Beta-Thalassemia Mutation
- Beta-Globin Gene Sequencing

REFLEX & REFERENCE TESTING:

Please note that additional testing procedures (i.e., reflex testing) will be performed when necessary and clinically indicated by the initial lab test results. Reflex testing will be billed to the appropriate payor in addition to the original test requested. This is particularly applicable to microbiology testing and other laboratory testing requiring confirmation or further diagnostic work.

All reference tests will be billed to the submitter at the prevailing reference laboratory's price with the addition of a handling fee.

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at **http://www.dshs.state.tx.us/lab/**.