TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

**G-2A Specimen Submission Form (SEP 2016)**
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.texas.gov/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. Specimen must have two (2) identifiers that match this form.

| Last Name ** | First Name ** | MI |
|---|---|---|
| Address ** | Telephone Number | |
| City ** | State ** / Zip Code ** | Country of Origin / Bi-National ID # |
| 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 # | Alien # / CUI / CDC ID | Previous DSHS Specimen Lab Number |
| **ICD Diagnosis Code ** (1)** | ICD Diagnosis Code ** (2) | ICD Diagnosis Code ** (3) |
| Date of Onset | Diagnosis / Symptoms | Risk |

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

## Section 3. SPECIMEN SOURCE OR TYPE

☐ Blood ☐ Oral fluid ☐ Other: _____
☐ Blood: Filter paper {DBS} ☐ Plasma
☐ CSF ☐ Serum

## Section 4. HIV SCREENING

☐ HIV Ag-Ab Multiplex {serum } ▲
☐ HIV 1 / 2 supplemental assay, serum ▲

## Section 5. SYPHILIS

☐ Syphilis Screening, IgG ▲
☐ Syphilis RPR {only} ● ▲
☐ Syphilis confirmation TP-PA ● ▲
● Justification: _____

## Section 7. ORDERING PHYSICIAN INFORMATION – (** REQUIRED)

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

## Section 8. 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 payer 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)
☐ BIDS (1720)
☐ BT Grant (1719)
☐ HIV / STD (1608)
☐ IDEAS (1610)
☐ Immunizations (1609)
☐ Refugee (7)
☐ Private Insurance (4)
☐ TB Elimination (1619)
☐ Title X (12)
☐ Title XX (13)
☐ TX CLPPP (9)
☐ Zoonosis (1620)
☐ Other: _____

| 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 9. CDC REFERENCE TESTS

☐ Cysticercosis @
☐ Echinococcus @
☐ HIV-2 @
☐ HTLV-I @
☐ Leptospirosis @
☐ Toxocariasis @
☐ VDRL (CSF only) @
☐ Other: @

## Section 6. REFERENCE SEROLOGY / IMMUNOLOGY

☐ Arbovirus (WN/SLE) (IgM) ▲
☐ Brucella ▲
☐ Chagas IgG
☐ Ehrlichia IFA ▲
☐ Hantavirus IgG / IgM ▲
☐ Hepatitis A IgM ▲
☐ Hepatitis A total ▲
☐ Hepatitis B core antibody (Ab) ▲
☐ Hepatitis B core IgM antibody ▲
☐ Hepatitis B surface antibody (Ab) ▲
☐ Hepatitis B surface antigen (Ag) ▲
☐ Hepatitis C (HCV) ▲
☐ Measles (IgG) ▲
☐ Measles IgM ▲
☐ Mumps IgG ▲
☐ Q-fever IgG ▲
☐ QuantiFERON (Tuberculosis serology) ▲
☐ Rickettsial panel (RMSF, typhus) ▲
☐ Rubella screen {IgG} ▲
☐ Rubella IgM ▲
☐ Schistosoma IgG EIA ▲
☐ Strongyloides IgG EIA ▲
☐ Tularemia (Francisella tularensis) ▲
☐ Yersinia pestis (Plague), serum ▲
☐ Other: ▲

NOTES: All dates must be entered in mm/dd/yyyy format.
● = Justification is required.
▲ = Document **date & time specimens were INCUBATED or** if stored in an appliance prior to shipping, document **date & time specimens were removed from FREEZER / REFRIGERATOR** in the bottom box.
@ = Provide patient history on reverse side of form to avoid delay of specimen processing.
Please see the form's instructions for details on how to complete this form. Visit: http://www.dshs.texas.gov/lab/.

**▲ REQUIRED for incubated shipments or cold/frozen shipments, if stored in an appliance.**

| Indicate removal from: ☐FREEZER ☐REFRIGERATOR ☐INCUBATOR | DATE | TIME |
|---|---|---|
| | | |

**FOR LABORATORY USE ONLY**

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

# G-2A Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.texas.gov/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.
Specimen must have two (2) identifiers that match this form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

**Place DSHS 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). If you are performing remote entry, place DSHS LIMS specimen bar code label here.

## 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.texas.gov/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 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/isolate.

**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 date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, country of origin telephone number, date of birth (DOB), date and time of collection, collected by, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, alien#/CUI, previous DSHS#, ICD diagnosis codes, , date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

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

All specimens must be labeled with at least two patient specific identifiers; both a primary and a secondary identifier. The identifiers must appear on both the primary specimen container (or card) and the associated submission form. Specimens that do not meet this criteria **will be considered unsatisfactory** for testing.

Acceptable identifiers are listed below:

| **List of Acceptable Identifiers** (2 identifiers are required to make a positive ID) | **Identifier Type** (Patient Name + at least 1 secondary ID) |
|---|---|
| **Patient Name** (last name, first name) | Primary **(required)** |
| **Date of Birth** | Secondary **(preferred)** |
| **Medical Record Number** | Secondary |
| **Social Security Number** | Secondary |
| **Medicaid Number** | Secondary |
| **Newborn Screening Kit Number** | Secondary |
| **CDC Number** | Secondary |

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label as long as the patient's first and last names are clearly identified as such. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

**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)**: Please list the date of birth. If the date of birth is not provided or is inaccurate, the 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 or other source. 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 # / Alien # / CUI:** Provide the identification number for matching purposes. For HIV screening, this number may be the eight-digit CDC number assigned to the patient. The CDC form sticker may be placed anywhere on the lower part of the form, as long as it does not obscure any tests ordered. 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), Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable):** Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

**Inpatient or Outpatient (if applicable):** Indicate if the patient is currently admitted to a hospital (required for TB patients).

**Outbreak/Surveillance (if applicable):** Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box. If this form is being submitted for flu surveillance, the following patient information is required: Date of Onset, Date of Collection, Diagnosis/Symptoms, and Risk. Dates must be entered into the **Date of Onset** and **Date of Collection** boxes. In the **Diagnosis/Symptoms** box, list all the symptoms from the following list that apply: 1) malaise, 2) sore throat, 3) nasal congestion, 4) fever, 5) chills, 6) cough, 7) headache, 8) myalgia. In the **Risk** box, indicate whether the patient received the flu vaccine this season and the date given.

**Section 3. SPECIMEN SOURCE OR TYPE**

**Specimen Source or Type:** Indicate the kind of material you are submitting or the source of the specimen or isolate. If specimen type is not listed here, specify under "Other:".

**Section 4. HIV SCREENING**

**HIV Ag-Ab:** HIV screening is performed by HIV Ag-Ab EIA multiplex for HIV detection and additional supplemental assays will be automatically performed to verify the presence of antibodies to HIV-1 or HIV-2 and HIV-1 p24 Ag by NAAT performed by the Dallas Co. Dept. of Health and Human Services at: 2377 N. Stemmons Freeway, Dallas TX 75207, CLIA # 45D0672012.

**Justification:**
Justification is required under 'HIV-1 / HIV-2 serum', Genius for HIV confirmation.

**Section 5. SYPHILIS**

**Syphilis screening, IgG:** Syphilis screening is performed by T. pallidum IgG EIA test using Reverse Syphilis Algorithm and if the IgG test is reactive the RPR with titer and TP-PA will be performed and a single report will be released with interpretation guidelines.

**Justification:** Justification is required for performing 'Syphilis RPR only' and 'Syphilis confirmation by TP-PA'. These tests will be available for treatment follow up and reflex testing purposes only. FTA-ABS test will no longer be offered to confirm discordant treponemal screening results.

**Section 6. REFERENCE SEROLOGY/IMMUNOLOGY**

Arbovirus IgM (WN/SLE) test is run as a panel for West Nile and St. Louis Encephalitis IgM antibodies by MAC-ELISA and Arbovirus IgG will be discontinued at the DSHS laboratory.

**Section 7. ORDERING 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 8. 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 a 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 web site at http://www.dshs.texas.gov/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.
- The submitter will be billed for anonymous HIV testing, unless the submitter has a current contract with the HIV/STD Program and marks HIV/STD as the Payor.

**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.

**TEST**

**Test Requested:** Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. For specific test instructions, see the Laboratory Services Section's web site at http://www.dshs.texas.gov/lab/. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Serum specimens must be refrigerated or frozen, depending on the test requested. DO NOT FREEZE serum separator tubes. *The time and date the specimen is removed from REFRIGERATOR or FREEZER **must** be provided to determine specimen acceptability. Please mark REFRIGERATOR or FREEZER accordingly.*

**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.

Patient history including travel and date of onset is **required** for CDC Reference tests under Section 10.

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

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For specific test instructions and information about tube types, see the Laboratory Services Section web site at **http://www.dshs.texas.gov/lab/**.