TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-MYCO 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** is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container. 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 #	**ICD Diagnosis Code ** (1)**	ICD Diagnosis Code ** (2) / ICD Diagnosis Code ** (3)

Section 3. SPECIMEN SOURCE OR TYPE -- (**REQUIRED)

- ☐ Abdominal fluid
- ☐ Abscess (site) _____
- ☐ Aspirate (site) _____
- ☐ BAL
- ☐ Biopsy (site) _____
- ☐ Bronchial washings
- ☐ Cervical
- ☐ CSF
- ☐ Eye
- ☐ Feces/Stool
- ☐ Gastric
- ☐ Lesion (site)_____
- ☐ Lymph node (site)_____
- ☐ Nasopharyngeal
- ☐ Pleural fluid/PLF
- ☐ Sputum: Induced
- ☐ Sputum: Natural
- ☐ Thoracentesis fluid
- ☐ Tissue (site) _____
- ☐ Vaginal
- ☐ Wound (site) _____
- ☐ Other: _____

Section 4. CLINICAL SPECIMEN

Is this specimen from an outbreak investigation? ☐ **Yes** ☐ **No**

Patient spends substantial time in a congregate setting (e.g. jail, homeless shelter)? ☐ **Yes** ☐ **No**

- ☐ AFB Smear Only (for release from Isolation)
- ☐ AFB Smear and Culture
- ☐ AFB Smear, Culture and Direct NAAT (Respiratory Diagnostic Specimens Only)

FOR RESPIRATORY DIAGNOSTIC SPECIMEN, PROCESSED SEDIMENT:

☐ Direct NAAT for M. tuberculosis (**NAAT ONLY – NO CULTURE PERFORMED**)
Please provide the AFB smear result for this processed sediment: _____

FOR AFB SMEAR POSITIVE SPECIMEN, PROCESSED SEDIMENT:

☐ Direct HPLC for Mycobacterium species, not M. tuberculosis
++++ *Prior authorization required* ++++
Telephone (512) 776-7342 for authorization.

Section 5. REFERRED PURE CULTURE

- ☐ Referred AFB Isolate Identification
- ☐ MTB Genotyping Only/for Compliance
- ☐ Fungal Isolate Identification
- ☐ Actinomycete, Aerobic, Identification

NOTES: Please see the form's instructions for details on how to complete this form.
Visit our web site at http://www.dshs.texas.gov/lab/.
All dates must be entered in mm/dd/yyyy format.

Section 6. ORDERING PHYSICIAN INFORMATION – (** REQUIRED)

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

Section 7. 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) ☐ Refugee (7)
☐ IDEAS (1610) ☐ TB Elimination (1619)
☐ Other: _____ ☐ Other: _____

HMO / Managed Care / Insurance Company Name *

Address *

City * / State * / Zip Code *

Responsible Party *

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 8. SUSCEPTIBILITY TESTING

Is MDR M. tuberculosis suspected? ☐ Yes ☐ No

Note: Drug susceptibility tests are performed automatically on patient's initial M. tuberculosis isolate.

☐ **MTB Primary Drug Susceptibility Panel**
- ☐ Ethambutol
- ☐ Isoniazid
- ☐ Pyrazinamide (PZA)
- ☐ Rifampin

☐ **MTB PZA Susceptibility Test Only**

☐ **MTB Agar Susceptibility Panel**
- ☐ Capreomycin
- ☐ Ethambutol
- ☐ Ethionamide
- ☐ Isoniazid
- ☐ Kanamycin
- ☐ Ofloxacin
- ☐ Rifabutin
- ☐ Rifampin
- ☐ Streptomycin

M. kansasii Susceptibility Test

☐ Agar, Rifampin

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

G-MYCO 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 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: 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, 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, and ICD diagnosis code.

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 (**). 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): Please list the date of birth**.** If the date of birth is not provided, 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. 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 (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.

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. **For mycobacteriology specimens, complete this section or the specimen will be rejected.**

For tuberculosis treatment, a specimen source or type MUST be provided for specimens used for the diagnosis or monitoring of TB. *DO NOT leave this section blank.*

For specimens other than those listed, check the "Other" box and write in the site and source selected from the TB Elimination Division's list of Anatomic Sites and Corresponding Specimen Sources, which can be obtained from your local or regional health department.
Test Requested: You **MUST** 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.

Section 4. CLINICAL SPECIMEN

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box.

Patient spends substantial time in a congregate setting (e.g. jail, homeless shelter): Indicate whether or not this patient is in a congregate setting as this would be an indication for rapid direct testing of a diagnostic specimen.

AFB Smear and Culture will always be performed on clinical specimens being tested by NAA. (NOTE: Except for laboratories shipping specimen sediment for Direct NAAT Only. See instruction below.)

Please ship urine specimens for AFB smear and culture to the DSHS South Texas Laboratory, Harlingen, Texas, using the F40-B specimen submission form.

Direct NAAT Only testing will only be performed on the sediment remaining from a processed respiratory specimen. **AFB culture must be in progress in the submitting laboratory.** Please provide the AFB Smear result obtained by the submitting laboratory.

Direct HPLC Only testing is performed by Special Request Only. Approval prior to specimen shipment must be obtained by telephoning 512-776-7342. Specimen is the sediment from an AFB Smear Positive processed specimen (no specimen source restriction). **AFB culture must be in progress in the submitting laboratory.**

Section 6. 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 7. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided, is inaccurate, or if 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 private 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) 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 8. SUSCEPTIBILITY TESTING

Please note that initial isolates of *M. tuberculosis* complex from a new patient will automatically be tested against the primary drug susceptibility panel.

REFLEX & REFERENCE TESTING:

Referred AFB Isolates will be identified by HPLC analysis. 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's web site at **http://www.dshs.texas.gov/lab/**.