



G-THSTEPS (SEP 2013)
Specimen Submission Form
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

FOR TEXAS HEALTH STEPS SPECIMENS ONLY !!!

IS THIS LABORATORY SUBMISSION PART OF THE THSTEPS MEDICAL CHECKUP OR FOLLOW-UP VISIT? Yes No

If Yes, what is the date of service for the medical checkup or follow-up visit? DATE: / /
MM DD YYYY

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, the specimen will be rejected.

Section 1. SUBMITTER INFORMATION -- (** REQUIRED)				Section 4. ORDERING PHYSICIAN INFORMATION -- (** REQUIRED)	
Submitter/TPI Number **		Submitter Name **		Ordering Physician's NPI Number **	
NPI Number **		Address **		Ordering Physician's Name **	
City **		State **	Zip Code **		Section 5. 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. If the Medicaid number is not provided or is inaccurate, the submitter will be billed. 4. Please write the Medicaid number in the space provided below.
Phone **		Contact			
Fax **		Clinic Code			
Section 2. PATIENT INFORMATION -- (** REQUIRED) NOTE: Patient name on specimen is REQUIRED & MUST match name on this form & Medicaid card.					
Last Name **		First Name **		Medicaid #: **	
		MI		Section 6. HL <input type="checkbox"/> Hemoglobin (Hb) <input type="checkbox"/> 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. <input type="checkbox"/> Yes	
Address **		Telephone Number			
City **		State **	Zip Code **	Country of Origin	
DOB (mm/dd/yyyy) **		Sex **	SSN	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian / Native Alaskan <input type="checkbox"/> Native Hawaiian / Pacific Islander		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Date of Collection ** (REQUIRED)		Time of Collection <input type="checkbox"/> AM <input type="checkbox"/> 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)	
Section 3. SPECIMEN TYPE					
<input type="checkbox"/> Blood: Capillary		<input type="checkbox"/> Plasma		<input type="checkbox"/> Urine	
<input type="checkbox"/> Blood: Venous		<input type="checkbox"/> Serum		<input type="checkbox"/> Vaginal	
<input type="checkbox"/> Endocervical		<input type="checkbox"/> Urethral		<input type="checkbox"/> Other:	
▲ REQUIRED for cold shipments. Indicate REMOVAL from: <input type="checkbox"/> FREEZER <input type="checkbox"/> REFRIGERATOR DATE (mm/dd/yyyy) TIME <input type="checkbox"/> AM <input type="checkbox"/> PM					
FOR LABORATORY USE ONLY Specimen Received: <input type="checkbox"/> Room Temp. <input type="checkbox"/> Cold <input type="checkbox"/> Frozen					

Contact Specimen Logistics via email at ClinicalChemistry@dshs.state.tx.us for assistance or questions.

G-THSTEPS 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. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

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.

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.

Contact Information/Collected By: 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, 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 Medicaid has been marked with double asterisks (**). These fields must be completed. You may use a pre-printed patient label.

Patient Name: The name on the specimen submission form and specimen must match the name on the Medicaid card.

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: Provide the identification number for matching purposes.

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 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. PHYSICIAN INFORMATION

Ordering Physician's NPI Number and Name: Give the physician's NPI number and name of the physician. **This information is required to bill THSteps.**

Section 5. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or is inaccurate.

- Write in the Medicaid number.
- If the patient name on the form does not match the name on the Medicaid card, the submitter will be billed.

Section 6. HL

Test Requested: Check or specify 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. STD

Note: Testing in this section is for age appropriate patients.

Test Requested: Check or specify 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.

Gonorrhea/Chlamydia (GC/CT) Amplified RNA probe: Testing for gonorrhea and chlamydia (GC/CT). Package specimen to ensure that the shipping temperature of 2°C-30°C (36°F-86°F) is maintained.

HIV & Syphilis RPR: Serum specimens must be refrigerated or frozen, according to 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.*

Syphilis RPR: Reflex testing (RPR titer, RPR confirmatory) will be performed on positive RPR screens.

Section 8. CHEMISTRIES

Test Requested: Check or specify the specific test(s) to be performed by the Laboratory Services Section. These specimens may be submitted to the submitter's laboratory of choice including the DSHS Laboratory for testing. 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: *The time and date the specimen is removed from FREEZER must be provided to determine specimen acceptability. Please mark FREEZER.*

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/>.