		F40-A-Specimen Submission Form												
<u> </u>		. (Jan 2022)												
TEXAS									Risso DSUS Bay Code Label / Address O. Crash Have					
	Texas Department o													
Services Health Services			CLIA #45D0503753 CAP #2148801						Place DSHS Bar Code Label / Address-O-Graph Here					
	www.dshs.texas.gov/lab/so tx lab													
P.(956) 364-8746 F.(956) 412-8794 www.dsns.texas.gov/lab/so_tx_lab Section 1. SUBMITTER INFORMATION – (** REQUIRED)														
Submitter/TPI Number ** Submitter Name **														
Cabinition III Hamber														
NPI Number ** Address									Section 3	ORDERING PHYS		ΜΔΤ		
										cian's NPI Number **	Ordering Phy			
City ** State *				e ** Zip Code **									¥.	
									Section 4 P	AYOR SOURCE -		יח		
Phone **				Contact						ATOK SOURCE -		.0)	•	
Those states and state				Contact						1. Reflex testing will be performed when necessary and the appropriate party will be				
Fax **	Clinic	Clinic Code					<ol> <li>billed.</li> <li>If the patient does not meet program eligibility requirements for the test requested</li> </ol>							
									and no third party payor will cover the testing, the submitter will be billed.					
Section 2. PATIENT INFORMATION (** REQUIRED)									<ol> <li>Medicare generally does not pay for screening tests please refer to applicable Third party payor guidelines for instructions regarding covered tests, benefit limitations,</li> </ol>					
NOTE: Patient n							dicaid card.		medical necessity determinations and Advanced Beneficiary Notice (ABN)					
Specimen must have two (2) id Last Name **				Identifiers that match this form First Name ** MI					requirements. 4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required.					
									Please write	it in the space provided	below.		•	
									<ol> <li>If private insurance is indicated, the required billing information below is designated with an asterisk (*).</li> </ol>					
Address **				Telephone Number						one box below to indica			the submitter,	
										edicare, private insuranc ledicaid (2)		am. edicare	2 (8)	
City ** State **				Zip Code ** Country of Origi					Medicaid/Me			uicar	5 (0)	
	214	2000			country of	2	weucalu/we							
DOB (mm/dd/yyyy) **	Sex **	Unique N	umbor		Pregna	nt?								
DOB (mm/dd/yyyy)	Sex	Unique N	unibei			_			Submi		Private			
						es		nknown		GTD (1608)	Other:			
White			Black or A	frican Ame			Hisp	oanic	OPC					
Race:								-						
Hispanic														
Native Hawaiian / Pacific Islander Other:     Unknown Date of Collection ** (REQUIRED) Time of Collection **     Collected By									•					
Medical Record #/Alien #/CU	I CDC ID			PM	e DSHS	Snecimen	Lab Number		HMO / Managed	Care / Insurance Compa	ny Name *			
	00010			1101100	0 DOI 10	opeoimen			Third / Managou	ouro / mourance compe				
ICD Diagnosis Code ** (1) ICD Diagnosis Code ** (2) ICD Diagnosis Code ** (3)									Address *					
									City *		State *	Zin (	code *	
Inpatient Outpatient Outbreak association:									Only		Olulo	Zip C		
Date of Onset (mm/dd/yyyy) Diagnosis / Symptoms Risk									Responsible Party (Last Name, First Name)*					
Section 5. CHEM P		Section 6. CHEMISTRY					Insurance Phone	Number * Re	esponsible Party's	Insuran	ce ID Number *			
■ Basic Metabolic Panel ♥		Album	nin		H	GGT								
			Ikaline Phosphatase			Glucose			Group Name		Group	Number		
Electrolytes Panel									"I boroby anthe	ze the release of information	tion related to the	con/	e described have and	
Hepatic Function Panel Amylase					=	Hemoglob				any benefits to which I	am entitled to the 1	Texas D	epartment of State	
			SGOT}							Health Services, Lal Signature of patie	oratory Services	Section.		
<b>TB Panel:</b> (ALT); (AST); (Alk Phos);				*	=		0 1 5	` '		Signature of palle		party.		
Image: TB Panel: (ALT); (AST); (Alk Phos);       Image: Bilirubin, Total       Image: Lactic Acid Dehydrogenase (LDH Billi, T); (BUN); (Chol); (Creat);         Billi, T); (BUN); (Chol); (Creat);       Image: Billirubin, total & direct profile       Image: Lipase														
(GGT); (Uric Acid) Blood Urea Nitrogen (BUN) Magnesium														
Section 7. URINAL	um													
Urine Micro Albumin Random				CO2)	=	Potassium			Signature *			Date	*	
Urinalysis *														
Microscopy with Urinalysis (UA)			sterol, Total Sodium							asting preferred for test.				
			esterol HDL	terol HDL Triglycerides					= Document time & date specimens were removed from REEZER/REFRIGERATOR in the lower right-hand box					
			esterol LDL Uric Acid											
			eatine kinase (CK)						*additional testing procedures will be ordered as reflex testing if clinically indicated.					
CBC automated with differential *														
Differential, Manual			Section 9. SPECIAL CHEMISTRY											
Hematocrit Hemoglobin, Total	Ferritin     Thyroid stimulating hormone (TSH)       FSH     Thyroxine (T4), free													
Peripheral Smear Review	=	LH Thyroxine (T4), Inee												
Sedimentation Rate (ESF		ctin	= '	· ·	ne (14), Total Hormone (T3) Uptake									
						onine (T3),			▲ REQUIR	ED for cold/frozen s	hipments, if st	ored i	n an appliance.	
		,			,	, · //			Indicate ren		DATE		TIME	
										REFRIGERATOR				
FOR LABORATORY USE ONLY Specimen Received: OROOM Temp.							Cold	Frozen						
		<u>-</u>				·`								

Laboratory Services Section/South Texas Lab: 1301 S.Rangerville Rd Harlingen, Tx 78552