



**F40-A**  
**Specimen Submission Form (SEP 2016)**  
 CLIA #45D0503753 CAP #2148801  
 Laboratory Services Section  
 South Texas Laboratory  
 1301 S. Rangerville Road  
 Harlingen, Texas 78552  
 (956) 364-8746  
 FAX: (956) 412-8794

Place DSHS Bar Code Label // Address-O-Graph Here

**Section 1. SUBMITTER INFORMATION - (\*\* REQUIRED)**

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

**Section 3. ORDERING PHYSICIAN INFORMATION - (\*\* REQUIRED)**

Ordering Physician's NPI Number **	Ordering Physician's Name **
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**Section 4. 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 tested 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.

<input type="checkbox"/> Medicaid (2)	<input type="checkbox"/> Medicare (8)
Medicaid/Medicare #:	
<input type="checkbox"/> Submitter (3)	<input type="checkbox"/> Private Insurance (4)
<input type="checkbox"/> BIDS (1720)	<input type="checkbox"/> TB Elimination (1619)
<input type="checkbox"/> BT Grant (1719)	<input type="checkbox"/> Title X (12)
<input type="checkbox"/> HIV / STD (1608)	<input type="checkbox"/> Title XX (13)
<input type="checkbox"/> OPC	<input type="checkbox"/> Other: _____

**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? <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		Ethnicity: <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Other: <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)	
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Outbreak association:	<input type="checkbox"/> Surveillance
Date of Onset (mm/dd/yyyy)	Diagnosis / Symptoms	Risk	

HMO / Managed Care / Insurance Company Name *		
Address *		
City *	State *	Zip Code *
Responsible Party (Last Name, First Name)*		

**Section 5. CHEM PANELS**

**Section 6. CHEMISTRY**

<input type="checkbox"/> Basic Metabolic Panel ▼	<input type="checkbox"/> Albumin	<input type="checkbox"/> GGT
<input type="checkbox"/> Comp Metabolic Panel ▼	<input type="checkbox"/> Alkaline Phosphatase	<input type="checkbox"/> Glucose
<input type="checkbox"/> Electrolytes Panel	<input type="checkbox"/> ALT {SGPT}	<input type="checkbox"/> Glucose tolerance, 2 Hr
<input type="checkbox"/> Hepatic Function Panel	<input type="checkbox"/> Amylase	<input type="checkbox"/> Glucose 2 Hr PP
<input type="checkbox"/> Lipid Profile Panel ▼	<input type="checkbox"/> AST {SGOT}	<input type="checkbox"/> Hemoglobin A1C
<input type="checkbox"/> Renal Function Panel	<input type="checkbox"/> Bilirubin, Direct	<input type="checkbox"/> Iron, Total
<input type="checkbox"/> TB Panel: (ALT); (AST); (Alk Phos); Billi, T); (BUN); (Chol); (Creat); (GGT); (Uric Acid)	<input type="checkbox"/> Bilirubin, Total	<input type="checkbox"/> Iron Binding Capacity, Total (TIBC)
	<input type="checkbox"/> Bilirubin, total & direct profile	<input type="checkbox"/> Lactic Acid Dehydrogenase (LDH)
	<input type="checkbox"/> Blood Urea Nitrogen (BUN)	<input type="checkbox"/> Lipase
	<input type="checkbox"/> Calcium	<input type="checkbox"/> Magnesium
	<input type="checkbox"/> Carbon dioxide (CO2)	<input type="checkbox"/> Phosphorus
	<input type="checkbox"/> Chloride	<input type="checkbox"/> Potassium
	<input type="checkbox"/> Cholesterol, Total	<input type="checkbox"/> Protein, Total
	<input type="checkbox"/> Cholesterol HDL	<input type="checkbox"/> Sodium
	<input type="checkbox"/> Cholesterol LDL	<input type="checkbox"/> Triglycerides
	<input type="checkbox"/> Creatine kinase (CK)	<input type="checkbox"/> Uric Acid
	<input type="checkbox"/> Creatinine	

**Section 7. URINALYSIS**

<input type="checkbox"/> Urine Micro Albumin Random
<input type="checkbox"/> Urine Microscopic Analysis
<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Microscopy with Urinalysis (UA)
<input type="checkbox"/> Rheumatoid Factor

**Section 8. HEMATOLOGY**

<input type="checkbox"/> CBC automated with differential
<input type="checkbox"/> Differential, Manual
<input type="checkbox"/> Hematocrit
<input type="checkbox"/> Hemoglobin, Total
<input type="checkbox"/> Peripheral Smear Review
<input type="checkbox"/> Sedimentation Rate (ESR)

**Section 9. SPECIAL CHEMISTRY**

<input type="checkbox"/> Ferritin	<input type="checkbox"/> Thyroid stimulating hormone (TSH)
<input type="checkbox"/> FSH	<input type="checkbox"/> Thyroxine (T4), free
<input type="checkbox"/> LH	<input type="checkbox"/> Thyroxine (T4), Total
<input type="checkbox"/> Prolactin	<input type="checkbox"/> Thyroid Hormone (T3) Uptake
<input type="checkbox"/> PSA, Total	<input type="checkbox"/> Tri-iodothyronine (T3), free

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 *
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**ADDITIONAL ORDERS:**

NOTES: ♥ = Fasting preferred for test.  
 ▲ = Document time & date specimens were removed from FREEZER/REFRIGERATOR in the lower right-hand box

<b>▲ REQUIRED for cold/frozen shipments, if stored in an appliance.</b>		
Indicate removal from:	DATE	TIME
<input type="checkbox"/> FREEZER <input type="checkbox"/> REFRIGERATOR		

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

## F40-A Specimen Submission Form's Instructions

For mailing and specimen packaging information, please contact South Texas Laboratory at (956) 364-8746.

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 / Address-O-Graph Here:** Place the DSHS specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place DSHS specimen bar code label here.

Imprint the Address-O-Graph card in this location, if applicable.

### 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](http://www.dshs.texas.gov/lab/mrs_forms.shtm#email).

**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 photocopy of a master form provided by the Laboratory Services Section.

**Contact:** Indicate the name, telephone, 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 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, collected by, medical record number, ICD diagnosis codes, and previous DSHS lab specimen number.

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:

<u>List of Acceptable Identifiers</u> (2 identifiers are required to make a positive ID)	<u>Identifier Type</u> (Patient Name + at least 1 secondary ID)
<b>Patient Name</b> (last name, first name)	Primary ( <b>required</b> )
<b>Date of Birth</b>	Secondary ( <b>preferred</b> )
<b>Medical Record Number</b>	Secondary
<b>Social Security Number</b>	Secondary
<b>Medicaid Number</b>	Secondary
<b>Newborn Screening Kit Number</b>	Secondary
<b>CDC Number</b>	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. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

**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:** Please 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 and Time of Collection fields are not completed or are inaccurate, the specimen will be rejected.**

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

**Medical Record#/Alien#/CUI/CDC#:** 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):** Indicate the diagnosis code(s) that would help in processing, identifying, and billing of this specimen.

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

**Outbreak/Surveillance Date of Onset, Diagnosis/Symptoms, and Risk (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. 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 4. 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.**

Checking 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.

Checking 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.

Checking 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](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 insurance.**
- 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.
- For BIDS (Border & Infectious Disease Surveillance) and OPC (Out Patient Clinic) check the appropriate box.

**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.

### **Sections 5-10:**

**Test Requested:** Check or specify the specific test(s) to be performed by the South Texas Laboratory.

### **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.

### **ADDITIONAL ORDERS**

*FOR OPC USE ONLY.*

Write in the additional tests to be performed by the South Texas Laboratory. Prior approval is required before additional tests may be requested. To obtain required approval for submission of test not found on listed on the specimen submission form, please contact South Texas Laboratory at (956) 364-8746.