



Texas Department of State Health Services

F40-TB Elimination Specimen Submission Form (Jan 2020)

CLIA #45D0503753 CAP #2148801

***DSHS LAB USE ONLY**

P: (956) 364-8746 FAX: (956) 412-8794 https://www.dshs.texas.gov/lab/so_tx_lab.shtm

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. Last Name, First Name, MI, Address, Telephone Number, City, State, Zip Code, Country of Origin, DOB, Sex, SSN, Pregnant?, Race, Ethnicity, Date of Collection, Time of Collection, AM/PM, Collected By

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

Ordering Physician's NPI Number, Ordering Physician's Name

Section 4. PAYOR SOURCE - (**REQUIRED)

- 1. Please do not use this form if not funded by the TB Elimination Program; use the F40-A specimen submission form. 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... 4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. 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.

TB Elimination (1619)

Medical Record Number, Alien # / CUI / CDC ID, Previous DSHS Specimen Label Number, ICD Diagnosis Code, Inpatient/Outpatient, Outbreak association, Date of Onset, 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

Basic Metabolic Panel, Comp Metabolic Panel, Hepatic Function Panel, Renal Function Panel, TB Panel, Albumin, Alkaline Phosphatase, ALT (SGPT), AST (SGO), Bilirubin, Direct, Bilirubin, Total, Blood Urea Nitrogen (BUN), Creatinine, Glucose, Hemoglobin A1C, Magnesium, Protein, Total, Uric Acid

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

Additional Information: (Yellow box)

REQUIRED for cold/frozen shipments, if stored in an appliance.

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

Indicate removal from: FREEZER, REFRIGERATOR, DATE, TIME

FOR LABORATORY USE ONLY

Specimen Received: Room Temp., Cold, Frozen