TEXAS Health and Human Services | Texas Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-MYCO Specimen Submission Form
(Jan 2022)

CAP# 3024401 CLIA 45D0660644

www.dshs.texas.gov/lab

*****FOR DSHS USE ONLY*****

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 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	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

FOR RAW UNPROCESSED SPECIMENS:

- ☐ AFB Smear Only (for release from Isolation)
- ☐ AFB Smear and Culture
- ☐ AFB Smear, Culture and Nucleic Acid Amplification (NAAT) for M. tuberculosis and Rifampin Resistance Detection (Respiratory Diagnostic Specimens Only)

FOR PROCESSED SEDIMENTS ONLY:

For Respiratory Diagnostic Specimen

- ☐ Nucleic Acid Amplification (NAAT) for M. tuberculosis and Rifampin Resistance Detection (NAAT ONLY – NO CULTURE PERFORMED)

For AFB Smear Positive Specimen

- ☐ 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) ☐ IDEAS (1610)
☐ TB Elimination (1619) ☐ Other: _____

HMO / Managed Care / Insurance Company Name *

Address:

City: / ST / 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 Plus Ofloxacin:**

- ☐ Ethambutol
- ☐ Isoniazid
- ☐ Pyrazinamide (PZA)
- ☐ Rifampin
- ☐ Ofloxacin

☐ **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