Medical Screening

G-1B Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Public Health Laboratory Division webpage at http://www.dshs.texas.gov/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 submission form.
Specimen must have two (2) identifiers that match the submission form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

Place DSHS Bar Code Label Here: Leave this space blank. It is for DSHS Lab Staff Use ONLY.

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) Public Health Laboratory Division assigns to each of our submitters. To request a DSHS Public Health Laboratory Division 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. For THSteps submitters: To obtain a Texas Provider Identifier (TPI) number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

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 submission form provided by the DSHS Public Health Laboratory. **Do not use any specimen submission forms with "SAMPLE" watermarked on it**. For updates or changes to submitter information, please contact Lab Reporting at (512) 776-7578.

Contact Information: 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.

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 (MRN), alien #, Accession ID, 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 specimen submission form.

All primary specimen containers must be labeled with at least two patient-specific identifiers, and they MUST match the identification on the submission form. Specimens that do not meet this criterion **will be considered unsatisfactory** for testing.

Acceptable identifiers are listed below:

List of Acceptable Identifiers (2 identifiers are required to make a positive ID)	**Identifier Type** (Patient Name + at least 1 secondary ID)
Patient Name (last name, first name)	Primary **(required)**
Date of Birth	Secondary **(preferred)**
Medical Record Number	Secondary
Unique Random Number	Secondary
Medicaid Number	Secondary
Newborn Screening Kit Number	Secondary
CDC Number	Secondary

Information that is required to bill Medicaid, Medicare, or private insurance has been marked with double asterisks (**). These fields must be completed. You may use a pre-printed patient label as long as the patient's first and last names are clearly identified as such.

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen submission form and specimen must match the name on the Medicaid, Medicare, and insurance card, respectively.

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.

Alien# / Accession ID / CDC ID: Provide the Alien number. Accession ID is the Clinic Unique Identifier number, CDC ID, if applicable.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Public Health 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.

Section 3. SPECIMEN TYPE

Specimen Type: Indicate the type of specimen that is being submitted.

Section 4. HEMOGLOBIN TYPE

Test Requested: Mark the hemoglobin type test to be performed by the DSHS Public Health Laboratory. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial. A selection box is considered marked when filled in, checked, or crossed with an 'X'. Do not circle selection boxes.

Section 5. PKU DIETARY MONITORING

Test Requested: Mark the Phenylalanine/Tyrosine test to be performed by the DSHS Public Health Laboratory. This test only includes measurement of phenylalanine and tyrosine and does not include the full Newborn Screening panel of tests. This does not satisfy the NBS requirement for a second screening. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial.

Section 6. HL

Test Requested: Mark the specific test(s) to be performed by the DSHS Public Health Laboratory. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial. A selection box is considered marked when filled in, checked, or crossed with an 'X'. Do not circle selection boxes.

Section 7. CHEMISTRIES

Test Requested: Mark the specific test(s) to be performed by the DSHS Public Health Laboratory. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial. A selection box is considered marked when filled in, checked, or crossed with an 'X'. Do not circle selection boxes.

Lipid Panel, Cholesterol, HDL, and Glucose Serum specimens must be frozen or refrigerated. DO NOT FREEZE serum separator tubes. Provide *the date and time and mark the appropriate appliance, FREEZER or REFRIGERATOR from which the specimens(s) were removed.* Specimens must be received at the DSHS Laboratory cold/frozen as appropriate for sample type submitted.

Section 8. PHYSICIAN INFORMATION

Ordering Physician's NPI Number and Name: Provide the physician's NPI number and physician's name. **This information is required to bill Medicaid, Medicare, and insurance.**

Section 9. 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.

Do not use this form for THSteps medical check-ups; use the G-THSTEPS specimen submission form.

If selecting 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.

If selecting Private Insurance:
- Mark the appropriate box.
- Complete all fields on the submission form that have an asterisk (*).
- If the patient name on the submission form does not match the name on the Medicaid card, the submitter will be billed.
- If the insurance information is not provided on the specimen submission form or is inaccurate, the submitter will be billed.
- Patient's DOB and address must be provided.

If selecting 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 DSHS Laboratory's Laboratory Testing Services Manual located on the web site at 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 private insurance.**
- For BIDS (Border & Infectious Disease Surveillance), CLPPP or IDEAS, check the appropriate box. Please check the "Other" box and list the program's name in the space provided if necessary.

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 submission 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: The responsible party must sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

Section 10. DNA ANALYSIS

Mark the specific test(s) and provide clinical diagnosis, if available. To cancel a test that is marked in error on the specimen submission form, mark one line through the test name, write "error", and initial.

The genes analyzed are β-Globin for hemoglobin testing, galactose-1-phosphate uridyl transferase for galactosemia testing, cystic fibrosis transmembrane conductance for cystic fibrosis testing, medium-chain acyl-CoA dehydrogenase for MCAD mutation panel testing, very long-chain acyl-CoA dehydrogenase for VLCAD gene sequencing and ATP-binding cassette subfamily D member 1 (ABCD1)

For all hemoglobin DNA tests, select the box. Available tests include:

- Hb S, C, E, D, or O-Arab
- Common Beta-Thalassemia Mutation
- Beta-Globin Gene Sequencing

For specific test instructions and information about tube types, see the DSHS Public Health Laboratory Division Laboratory Testing Services Manual on our web site at **http://www.dshs.texas.gov/lab/**.