G2-A Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Public Health Laboratory Division webpage: www.dshs.texas.gov

Avoid common errors:

- ✓ 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.
- ✓ A selection box is considered marked when filled in, checked, or crossed with an 'X'. Do not circle selection boxes.
- ✓ Do not use the form for THSteps medical check-ups; use the G-THS specimen submission form.

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 https://dshs.texas.gov/lab/mrs_forms.shtm. 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 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/#/.

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 form provided by the Public Health Laboratory Division . 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/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 date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, country of origin telephone number, date of birth (DOB), date and time of collection, collected by, sex, pregnant, race, ethnicity, medical record number, alien#/CUI, previous DSHS#, ICD diagnosis codes, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen must match the patient's name listed on the specimen submission 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 these criteria will be considered unsatisfactory for testing.

Acceptable Identifiers:

- Patient Name (last name, first name)
- Date of Birth
- Medical Record number
- Unique Number
- Medicaid Number
- Newborn Screening Number
- CDC Number

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label as long as the patient's first and last names are clearly identified as such. For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.

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

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: 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 or other source. 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 # / Alien # / CUI: 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), Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

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

Outbreak/Surveillance (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.

Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. If specimen type is not listed here, specify under "Other:".

Indicate the specimen storage conditions, by checking whether the specimen was refrigerated or frozen, and indicating the date and time the specimen was removed from storage.

Section 4. HIV/STD SCREENING

HIV Screen: HIV screening is performed at DSHS according to the CDC's recommended HIV testing algorithm. Initial testing is performed by multiplex flow immunoassay intended for the simultaneous qualitative detection and differentiation of the HIV-1 p24 antigen, HIV-1 (group M and O) antibodies, and HIV-2 antibodies in human serum. This assay is intended as an aid in diagnosis of infection with HIV-1 and/or HIV-2, including acute (primary) HIV-1 infection. Specimens with a reactive result are confirmed by a HIV-1/HIV-2 Supplemental Assay and/or NAAT. A single report will be released with interpretation guidelines.

HIV-1 RNA NAAT only: Justification is required. HIV-1 RNA NAAT may be requested for the following purposes: To monitor the effects of antiretroviral treatment, as part of the new PrEP testing algorithm, to assess for perinatal exposure, and to resolve discordant HIV serology results. Plasma is the only acceptable specimen source for monitoring antiretroviral treatment.

Syphilis Screen: Syphilis screening at DSHS is based on the CDC's recommended Reverse Syphilis Algorithm. Specimens are screened for qualitative detection of *Treponema pallidum* IgM and IgG antibodies by multiplex flow immunoassay. If antibodies are detected, specimens are then tested by the RPR assay (if reactive then a titer will be performed) and TPPA per the algorithm. A single report will be released with interpretation guidelines.

Syphilis RPR and Syphilis Confirmation by TP-PA: Justifications are required. Both Syphilis RPR and Syphilis Confirmation by TP-PA should be requested to confirm positive point-of-care (POC) test results. Syphilis RPR can also be requested for post-treatment monitoring. Post-treatment RPR testing should be accomplished using the same method as the baseline RPR test.

Section 5. HEPATITS TESTING

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Public Health Laboratory Division . For specific test instructions, see the Public Health Laboratory Division web site at Directory of DSHS Laboratory Tests and Specimen Requirements | Texas DSHS. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Hepatitis C RNA, Quantitative NAAT: Justification is required. Hepatitis C RNA, Quantitative NAAT may be requested for the following purposes: To monitor the effects of antiretroviral treatment, to assess for perinatal exposure in infants 2-18 months, and to assess HCV infection in people with suspected exposure within the past 6 months. Serum specimens must be refrigerated or frozen, depending on the test requested. DO NOT FREEZE serum separator tubes.

Section 6. SEROLOGICAL REFERENCE TESTING

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Public Health Laboratory Division . For specific test instructions, see the Public Health Laboratory Division web site at Directory of DSHS Laboratory Tests and Specimen Requirements | Texas DSHS. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Serum specimens must be refrigerated or frozen, depending on the test requested. DO NOT FREEZE serum separator tubes.

Section 7. ORDERING PHYSICAN INFORMATION

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

Section 8. 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**.

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 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.

If selecting 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 Public Health Laboratory Division web site at http://www.dshs.texas.gov/lab/.
- 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), or IDEAS/EAIDU, check the appropriate box.
- The submitter will be billed for anonymous HIV testing, unless the submitter has a current contract with the DSHS HIV/STD Program and marks HIV Prevention or Public Health Follow Up (PHFU) as the Payor.

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.

Section 9. CDC REFERENCE TEST

CDC accepts specimens from state public health laboratories and other federal agencies for analysis. Specimens from private healthcare providers and institutions must be submitted to the local state health department laboratory (state, county, city) for appropriate processing. All specimen submissions to CDC must have approval by the individual state health department, unless participating in special studies or surveillance projects.

See https://www.cdc.gov/laboratory/specimen-submission/index.html for the CDC's online test directory, the CDC 50.34 Specimen Submission Form and other supporting documentation.

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

A completed CDC 50.34 Specimen Submission Form should accompany the completed G2-A form for the specimen. Patient history including travel and date of onset is **required** for CDC Reference tests under Section 8.