G-2B 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.

Place DSHS Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system (LIMS). If you are performing remote entry, place DSHS LIMS specimen bar code label here.

Section 1. SUBMITTER

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 obtain a Texas Provider Identifier (TPI) number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

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.state.tx.us/lab/mrs_forms.shtm#email, see section for Submitter Account Request Forms

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#/.

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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.

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.

Section 2. PATIENT

Complete all patient information including date of collection, time of collection, (now under Specimen), last name, first name, middle initial, address, city, state, zip code, country of origin, telephone number, date of birth (DOB), (under specimen), sex, pregnant, race, ethnicity, (under specimen), ICD diagnosis code, 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 as listed on the 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 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
- CDC Number

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.

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, the specimen may be rejected.

Pregnant: Indicate if female patient is pregnant by marking either Yes, No, or Unknown.

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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.

Section 3. SPECIMEN

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. 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.

Specimen Source or Type: Select one type of material you are submitting. If submitting a bacterial sample, select a single source from which the organism(s) was isolated.

For specimens other than those listed, check the "Other" box and write in the site and source selected from the TB Elimination Division's list of Anatomic Sites and Corresponding Specimen Sources (is this accurate for the G-2B?), which can be obtained from your local or regional health department.

Section 4.1 TEST REQUEST

Test Requested: You **MUST** check or specify the specific test(s) to be performed by the DSHS Public Health Laboratory Division. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "4.2 Bacteriology" or "4.3 Parasitology". For specific test instructions, see the Public Health Laboratory Division sat http://www.dshs.texas.gov/laboratory-services.
For tests marked with a **Θ** or "◆" attach prior lab results or relevant patient history to avoid processing delays

Section 4.2 BACTERIOLOGY

Clinical Specimens: Select test requested. For specimens submitted to comply with Texas Administrative Code (TAC) §97.3 (a) (4) or requested for outbreak investigation[i] **use section 9.**

Gonorrhea (GC)/Chlamydia: Please follow the instructions listed below when submitting *Neisseria gonorrhoeae* and *Chlamydia trachomatis* specimens.

Under the "Bacteriology" section of the form:

1. Under "Clinical specimens:"
   a. Check the box marked "GC/CT, amplified RNA probe" if submitting for APTIMA testing.
2. Under "Pure cultures:"
   a. If *Neisseria gonorrhoeae* is isolated and a pure culture is being submitted, please check the box "Neisseria" or attach a copy of any lab work performed at your facility.

Definitive Identification: Write in organism suspected. Check box by test requested. Please attach test results or additional relevant information. The back of this form may also be used for this purpose.

Section 4.3 PARASITOLOGY

Please indicate the suspected organism for any test that is not a routine fecal O&P (ova and parasite). A brief patient history is requested on tests marked with the "◆" symbol. Please notify the Medical Parasitology Team at 512-776-7560 before submitting unusual specimens, to receive proper handling instructions.

Section 4.4. MOLECULAR STUDIES

PCR: Select test(s) requested. If epidemiology requests WGS, select the WGS box. Indicate in Section 2 if the sample is part of an outbreak.

For special test requests, contact Molecular Biology at (888) 963-7111 x7784 or (512) 776-7784 prior to submitting specimens.

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Section 5. ORDERING 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 6. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided, is inaccurate, or if 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 private 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's 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), or IDEAS/EAIDU, 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 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.

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.

For specific test instructions and information about tube types, see the Public Health Laboratory Division at **http://www.dshs.texas.gov/laboratory-services/**.

[i] Note that other required isolates are included on the G-27A Specimen Submission Form.

Please do not use this form for THSteps Medical Check-ups; use the G-THSTEPS specimen submission form.