G-2V Virology Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Public Health Laboratory Division Section 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: 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 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.texas.gov/lab/mrs_forms.shtm#email.

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/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 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: 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

All patient information that is required is marked with double asterisks (**).

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 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 are listed below:

- 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.

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. 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-REQUIRED** (required):** Indicate if the patient is currently admitted to a hospital (required for TB patients).

****Outbreak/Surveillance-REQUIRED** (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.

Section 4. VIROLOGY

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. For specific test instructions, see the Laboratory Services Section's web site at http://www.dshs.state.tx/lab/. 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 with filled in, checked, or crossed with an X. Do not circle selection boxes.

For flu surveillance specimens: Specimens submitted for influenza surveillance will be initially screened for Influenza A and Influenza B using the CDC real time RT-PCR assay for detection of influenza and/or the CDC real time RT-PCR multiplex assay for detection of influenza and COVID. All positive Influenza A specimens will be sub-typed for, seasonal H3, or 2009 Influenza H1N1.

Section 5. ORDERING PHYSICIAN 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 6. 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.

Please do not use this form for THSteps Well Child 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's 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'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, 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.

Section 7. ARBOVIRUSES / ZOONOTIC

If Zika, Dengue, Chikungunya, West Nile (WN) and/or St. Louis Encephalitis (SLE) is/are suspected, please select the box(es) in Section 7. Serology, PCR, or both will be performed at DSHS and the testing methodology and specific viruses approved for testing will be based on clinical symptoms and epidemiological criteria. In some instances, specimens may also be forwarded to CDC for further testing.

Prior to shipping specimens for arbovirus testing: Contact your Local Health Department or DSHS Health Service Region (http://www.dshs.texas.gov/Regions/lhds.shtm) to ensure patient meets criteria for testing. For further information please go to http://www.texaszika.org.

NOTE: Do not use the G-2A Specimen Submission Form to request any Zika, Dengue, Chikungunya, West Nile (WN) and/or St. Louis Encephalitis (SLE) serology testing. Please use the G-2V Specimen Submission Form for these tests.

REMINDER: If ordering Zika, Dengue, and/or Chikungunya, please mark "Zoonosis" as the Payor Source.

Serum specimens must be refrigerated or frozen, depending on the test requested. DO NOT FREEZE serum separator tubes. *The time and date the specimen is removed from REFRIGERATOR or FREEZER **must** be provided to determine specimen acceptability. Please mark REFRIGERATOR or FREEZER accordingly. If samples are removed from freezer, ship on dry ice.*

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's web site at **http://www.dshs.texas.gov/lab/**.