

G-MYCO Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Public Health Laboratory Division web page at <http://www.dshs.texas.gov/lab/>.

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 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 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 Laboratory Services Section. **Do not use any specimen submission forms with "SAMPLE" watermarked on it.** For updates or changes, 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, 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, and ICD diagnosis code.

NOTE: The patient's name listed on the specimen **must** match the patient's name listed on the 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 this 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 (**). 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 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.

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 (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.

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. **For mycobacteriology specimens, complete this section or the specimen will be rejected.**

For tuberculosis treatment, a specimen source or type **MUST** be provided for specimens used for the diagnosis or monitoring of TB. **DO NOT leave this section blank.**

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, which can be obtained from your local or regional health department.

Test Requested: You **MUST** 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 <http://www.dshs.texas.gov/lab/>. To cancel a test that is marked in error on the form, mark one line through the test name, write "error", and initial.

Section 4. CLINICAL SPECIMEN

AFB Smear and Culture will always be performed on clinical specimens being tested by NAA. (NOTE: Except for laboratories shipping specimen sediment for Direct NAAT Only. See instruction below.)

Please ship urine specimens for AFB smear and culture to the DSHS South Texas Laboratory, Harlingen, Texas, using the F40-B specimen submission form.

Direct NAAT Only testing will only be performed on the sediment remaining from a processed respiratory specimen. **AFB culture must be in progress in the submitting laboratory.** Please provide the AFB Smear result obtained by the submitting laboratory.

Direct HPLC Only testing is performed by Special Request Only. Approval prior to specimen shipment must be obtained by telephoning 512-776-7342. Specimen is the sediment from an AFB Smear Positive processed specimen (no specimen source restriction). **AFB culture must be in progress in the submitting laboratory.**

Section 6. 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 7. 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.

Please do not use this form for THSteps medical check-ups; use the G-THSTEPS 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 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 website 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 8. SUSCEPTIBILITY TESTING

Please note that initial isolates of *M. tuberculosis* complex from a new patient will automatically be tested against the primary drug susceptibility panel.

REFLEX & REFERENCE TESTING:

Referred AFB Isolates will be identified by HPLC analysis. 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 web site at <http://www.dshs.texas.gov/lab/>.