TEXAS Health and Human Services | Texas Department of State Health Services

P.O. Box 149347
Austin, Texas 78714-9347

Form #F14-13277
January 2025

SUBMITTER IDENTIFICATION (ID) NUMBER REQUEST FORM

If you have any questions, please call Submitter ID Coordinator at (512) 776-2484 or toll free at 1-888-963-7111 ext. 2484.

Fax the completed form to Demetrist Wallace at (512) 776-7533

1. SUBMITTER INFORMATION

** REQUIRED

Facility Name:		
Address:		
City:	**State:**	**Zip Code:**
Phone Number **	**Fax ****	**Contact Name and/or Email Address**
NPI # (Required):	**TPI # (THS Only):**	**Submitter ID #:**

2. Reason for submitting form?

** REQUIRED

☐ New Submitter ID number
(complete # 1-7)

☐ Updating submitter information
(complete # 1-8)

☐ Closed Account
(complete # 1-4)

3. Contact Information

Contact Person Name: (Required):	**Phone Number: (Required):**
Email Address: (Required):	**Fax Number:**

4. Please select the type of test(s) that will be requested (specimen submitted for ????):

☐ Newborn Screening ☐ Clinical Chemistry (Lead, Total Hemoglobin, Hgb Electro, Glucose, etc.) ☐ Microbiology (TB, STD, Covid, etc.)

5. Preferred method of delivery of test results? (Only Check one)

☐ U.S. Mail ☐ Fax ☐ Web ☐ HL7 (NBS Only)

6. Check one box that best describes the submitter? (Only Check one)

☐ Birthing Center ☐ Case Manager ☐ Clinic ☐ Endocrinologist ☐ Geneticist ☐ Health Department ☐ Health Dept. Sub-Office
☐ Hematologist ☐ Hospital ☐ Laboratory ☐ Midwife ☐ Nurse ☐ Physician ☐ Physician Office
☐ Prison System ☐Veterinarian ☐ Other (discribe) _____

7. Is the Submitter's address information the same as the mailing address for test results, supplies, and billing?

NEWBORN ONLY ☐ Yes ☐ No If No, please provide additional address information below

Additional Address 1: for ☐ shipping ☐ billing			Additional Address 2: for ☐ shipping ☐ billing		
ATTN:			**ATTN:**		
Street Address or P.O. Box:			**Street Address or P.O. Box:**		
City:	**State:**	**Zip Code:**	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Phone:**	**Fax:**	

8. Old Address Information: (if requesting address change)

Old Address 1: for ☐ test results ☐ shipping ☐ billing			Old Address 2: for ☐ test results ☐ shipping ☐ billing		
ATTN:			**ATTN:**		
Street Address or P.O. Box:			**Street Address or P.O. Box:**		
City:	**State:**	**Zip Code:**	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Phone:**	**Fax:**	

DSHS Use Only:

Submitter ID Number Assigned: (Requestor Code)	LIMS:
	☐ PerkinElmer ☐ LabWare ☐ Harvest ☐ Access ☐ Explanation of any changes to existing information noted in LIMS communication log

Notified:

☐ Submitter ☐ Container Prep / Lab Supply ☐ LabAR ☐ Customer Service ☐ STL

Completed By:

Name:	Date: