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

Specimen Acquisition: (512) 776-7598

G-2A Specimen Submission Form (Jan 2020) Rev.1.

CAP# 302440 CLIA #45D0660644

www.dshs.texas.gov/lab

******For DSHS Use Only*****

Section 1. SUBMITTER INFORMATION (** REQUIRED)

Submitter/TPI Number ** | Submitter Name **

NPI Number ** | Address **

City ** | State ** | Zip Code **

Phone ** | Contact

Fax ** | Clinic Code

Section 2. PATIENT INFORMATION (** REQUIRED)

NOTE: **Patient name** on specimen **MUST** match name on this form & Medicaid/Medicare card.
Specimen must have two (2) identifiers that match this form.

Last Name ** | First Name ** | MI

Address ** | Telephone Number

City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

DOB (mm/dd/yyyy) ** | Sex** | Pregnant? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Date of Collection ** **(REQUIRED)** | Time of Collection ☐ AM ☐ PM | Collected By

Medical Record #/Alien #/CUI | CDC ID | Previous DSHS Specimen Lab Number

ICD Diagnosis Code ** (1) | ICD Diagnosis Code ** (2) | ICD Diagnosis Code ** (3)

Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association ☐ Surveillance

Section 3. SPECIMEN SOURCE / TYPE *(**REQUIRED)*

☐ Blood ☐ CSF ☐ Serum ☐ Plasma ☐ Other: _____

Document storage conditions, date and time specimens were removed from storage:

☐ FREEZER ☐ DATE: (mm/dd/yyyy): _____

☐ REFRIGERATOR ☐ TIME (HR:MM) _____ ☐ AM ☐ PM

Section 7. ORDERING PHYSICIAN INFORMATION (** REQUIRED)

Ordering Physician's NPI Number ** | Ordering Physician's Name **

Section 8. PAYOR SOURCE (REQUIRED)

1. **Reflex testing** will be performed when necessary and the appropriate party will be billed.
2. If the patient does not meet program eligibility requirements for the test requested and no third party payor will cover the testing, **the submitter will be billed**.
3. Medicare generally does not pay for screening tests-please refer to applicable Third party payer guidelines for instructions regarding covered tests, benefit limitations, medical necessity determinations and Advanced Beneficiary Notice (ABN) requirements.
4. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. Please **write** it in the space provided below.
5. If private insurance is indicated, the required billing information below is designated with an asterisk (*).
6. **Check only one box** below to indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program **«SubmID»**

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

☐ Submitter (3) ☐ Private Insurance (4)

☐ BIDS (1720) ☐ TB Elimination (1619)

☐ HIV/STD (1608) ☐ Zoonosis (1620)

☐ IDEAS (1610) ☐ Other: _____

☐ Immunizations (1609)

HMO / Managed Care / Insurance Company Name *

Address *

City * | State* | Zip Code*

Responsible Party (Last Name, First Name) *

Insurance Phone Number * | Responsible Party's Insurance ID Number *

Group Name | Group Number

I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature* | Date*

COVID-19

☐ SARS CoV-2 Antibody

The centrifuged and separated specimens can be stored at 2-8°C if the specimens will be received at DSHS within 4 days.

If the specimens will not be received within 4 days, freeze the specimens at -20°C or colder and ship on dry ice.

Section 4. HIV/STD TESTING

☐ HIV Screen ☐ Syphilis Screen ☐ Syphilis RPR Only: Justification Required: _____ ☐ Syphilis Confirmation by TP-PA: Justification Required: _____

Section 5. HEPATITIS TESTING

☐ Hepatitis A IgM
☐ Hepatitis A, Total (IgM/IgG)
☐ Hepatitis B Core Antibody IgM
☐ Hepatitis B Core Total Antibodies (IgM,IgG)
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Surface Antigen
☐ Hepatitis C Antibody

Section 6. SEROLOGICAL REFERENCE TESTING

☐ Brucella IgG ☐ Q-Fever IgG
☐ Ehrlichia IgG ☐ Rocky Mountain Spotted Fever & Typhus Fever Panel IgG
☐ Hantavirus IgM & IgG ☐ Rubella IgM
☐ Measles IgM ☐ Rubella IgG
☐ Measles IgG ☐ Schistosoma IgG
☐ Mumps IgG ☐ Strongyloides IgG
☐ Plague IgG ☐ Tularemia IgG

Section 9. CDC REFERENCE TESTS

Provide patient history on reverse side of form or attach to avoid delay of specimen processing

☐ Chagas Disease ☐ Leptospirosis
☐ Cysticercosis ☐ Paragonimiasis
☐ Echinococcosis ☐ VRDL (CSF only)
☐ Fascioliasis ☐ Other: _____
☐ HTLV-1

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen