TEXAS Department of State Health Services

Specimen Acquisition: (512) 776-7598

G-2V Virology Specimen Submission Form (JUL 2016)
CAP# 3024401 CLIA #45D0660644
Laboratory Services Section, MC-1947
P. O. Box 149347, Austin, Texas 78714-9347
Courier: 1100 W. 49th Street, Austin, Texas 78756
(888) 963-7111 x7318 or (512) 776-7318
http://www.dshs.texas.gov/lab

****For DSHS Use Only****
Place DSHS Bar Code Label Here

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 is **REQUIRED & MUST** match name on this form & Medicare/Medicaid 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) ** / Age / Sex ** / SSN	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 OR TYPE

- ☐ Abscess (site) _____
- ☐ Blood
- ☐ Bone marrow
- ☐ Bronchial washings
- ☐ Buccal swab
- ☐ CSF
- ☐ Eye
- ☐ Feces/stool
- ☐ Lesion (site)_____
- ☐ Lymph node (site)_____
- ☐ Nasopharyngeal: ☐wash ☐swab ☐aspirate
- ☐ Nasal Swab
- ☐ Nasal Wash
- ☐ Oral fluid
- ☐ Rectal swab
- ☐ Serum:
  - Acute date: ___/___/___
  - Conval. date: ___/___/___
- ☐ Sputum: Induced
- ☐ Sputum: Natural
- ☐ Throat swab
- ☐ Tissue (site) _____
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Wound (site) _____
- ☐ Other: _____

Section 4. VIROLOGY

☐ Electron Microscopy

☐ Influenza surveillance {Influenza real-time RT-PCR}
Vaccine received: ☐ Yes ☐ No
Date vaccine received: _____
Travel history (if known): _____

☐ Measles, real-time RT-PCR

☐ Mumps, real-time RT-PCR

☐ MERS Coronavirus (Novel coronavirus)
++++ ***Prior authorization required***. ++++
Call Infectious Disease (512) 776-7676 for authorization

☐ Other: _____

Section 5. ORDERING PHYSICIAN INFORMATION – (** REQUIRED)

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

Section 6. 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 payor 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.

☐ Medicaid (2) ☐ Medicare (8)

Medicaid/Medicare #: _____

- ☐ Submitter (3)
- ☐ BIDS (1720)
- ☐ BT Grant (1719)
- ☐ HIV / STD (1608)
- ☐ IDEAS (1610)
- ☐ Immunizations (1609)
- ☐ Refugee (7)
- ☐ Private Insurance (4)
- ☐ TB Elimination (1619)
- ☐ Title X (12)
- ☐ Title XX (13)
- ☐ TX CLPPP (9)
- ☐ Zoonosis (1620)
- ☐ Other: _____

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 *

Section 7. ZIKA, DENGUE, CHIKUNGUNYA

☐ Zika, Dengue, and/or Chikungunya

NOTE: 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.

***** FOR DSHS USE ONLY *****

Testing Criteria? ☐ Met ☐ Not Met

PCR:	Serology:	Initials:	Date:
☐ C ☐ D ☐ Z	☐ C ☐ D ☐ Z		

NOTES: All dates must be entered in mm/dd/yyyy format.
Please see the form's instructions for details on how to complete this form. Visit: http://www.dshs.texas.gov/lab/.

FOR LABORATORY USE ONLY

Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

G-2V Virology Specimen Submission Form Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.texas.gov/lab/.

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 the form.
If the Date of Collection field is not completed or is inaccurate, the specimen will be rejected.

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) Laboratory Services Section 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 Laboratory Services Section 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 Laboratory Services Section.

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, 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, social security number (SSN), 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 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:

List of Acceptable Identifiers (2 identifiers are required to make a positive ID)	**Identifier Type** (Patient Name + at least 1 secondary ID)
Patient Name (last name, first name)	Primary **(required)**
Date of Birth	Secondary **(preferred)**
Medical Record Number	Secondary
Social Security Number	Secondary
Medicaid Number	Secondary
Newborn Screening Kit Number	Secondary
CDC Number	Secondary

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 (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. 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. Tests requiring Acute/Convalescent sera and dates are indicated with a '§' in the testing area of the form.

TEST

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 form, mark one line through the test name, write "error", and initial.

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.*

Section 4. VIROLOGY

For flu surveillance specimens: Except in certain situations (epidemiological investigations, other public health outbreaks, seasonal changes, etc.), influenza surveillance specimens will not initially receive viral isolation. 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. All positive Influenza A specimens will be sub-typed for seasonal H1, seasonal H3, or 2009 Influenza H1N1. Viral isolation in tissue culture will be performed during off-peak influenza months (i.e., summer) or as dictated by the circulation of a significant strain of the influenza virus.

Section 7. ZIKA, DENGUE, CHIKUNGUNYA

If Zika, Dengue, and/or Chikungunya is/are suspected, please select the box 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: Contact your Local Health Department or DSHS Health Service Region (http://www.dshs.state.tx.us/Regions/lhds.shtm) to ensure patient meets criteria for testing. For further information please go to http://www.texaszika.org.

If requesting West Nile (WN) and/or St. Louis Encephalitis (SLE) serology, please use the G2A submission form.

NOTE: Do not use the G-2A Specimen Submission Form to request any Zika, Dengue, Chikunguyna testing. Please use the G-2V Specimen Submission Form for these tests.

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 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 or 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 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 Laboratory Services Section'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), CLPPP 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.

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.

All reference tests will be billed to the submitter at the prevailing reference laboratory's price with the addition of a handling fee.

For specific test instructions and information about tube types, see the Laboratory Services Section's web site at **http://www.dshs.texas.gov/lab/**.