



Section 3. CLINICIAN INFORMATION (REQUIRED)**

Ordering Clinician's Name ** Ordering Clinician's NPI **

Section 4. 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, Medicare or THSteps 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.
 - THSteps Medicaid Medicare
- Medicaid/Medicare #: _____
 Medicare # _____
 Private Insurance # _____
 Medicare HMO # _____
 HIV/STD # _____
 RGSC # _____
 TB Elimination # _____
 TIPP # _____
 Title X # _____
 Title XX # _____
- Private Insurance # _____
 Medicare HMO # _____
 Title V-Family Planning # _____
 Title V-Dysplasia # _____
 Title V-Prenatal # _____
 Title V-Child Health # _____
 TCID # _____
 Other # _____

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter # ** (8-digit code) Submitter Name **

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: Patient name on specimen is REQUIRED & MUST match name on this form & Medicare/Medicaid card.

Last Name ** First Name ** MI

Address ** Telephone Number

City ** State ** Zip Code ** Country of Origin

Race: White Black or African American Hispanic
 American Indian / Native Alaskan Asian Non-Hispanic
 Native Hawaiian / Pacific Islander Other: Unknown

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

Date of Collection ** (REQUIRED) Time of Collection** AM PM Contact/Collected by

Medical Record # / Alien # / CUI / CDC Id ICD Diagnosis Code ** ICD Diagnosis Code ** ICD Diagnosis Code **

Section 5 CLINICAL HISTORY

Narrative:
 LMP:
 High Risk Prv Abn Hormone Pregnant
 Post Partum PMP Hysterectomy Prior Bx
 Tuberculosis Hx of Std Colposcopy Prior LEEP

Section 6. STD SCREEN HISTORY

Reason for Exam: Diagnostic Presumptive Chlamydia
 Screening Treatment this visit: Gonorrhea
 Recheck High Risk for STD: Yes No

Section 7. SPECIMEN SOURCE OR TYPE – (* REQUIRED, except blood)

Cervical Endocervical Vaginal
 Urine Urethral Urogenital Other _____
Surgical Pathology: (Attach Colposcopy or Exam Form)
 Cx Bx at _____ Cx Bx at _____ ECC
 EMB Leep at _____ Leep at _____
 Other _____ Other _____ Other _____

Section 8. SPECIMEN PRIORITY

STAT Routine

Address **
 City ** State ** Zip **

Responsible Party (Last Name, First Name) **

Insurance Phone Number** Responsible Party Insurance ID Number**

Group Number Group Name

"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**

CYTOLOGY		Specimen	MICROBIOLOGY		Specimen	CHEMISTRY		Specimen	IMMUNOLOGY		Specimen
<input type="checkbox"/>	Conventional PapSmear*	Pap	<input type="checkbox"/>	Acid Fast Culture and Smear*	SI/O	<input type="checkbox"/>	Albumin	T	<input type="checkbox"/>	Hep Bs Ag	T
<input type="checkbox"/>	Liquid Based PapSmear*	L	<input type="checkbox"/>	Bacterial Culture*	CS/O	<input type="checkbox"/>	ALT	T	<input type="checkbox"/>	HIV, Serum	T
<input type="checkbox"/>	Liquid Based PapSmear* w/HPV regardless of results	L	<input type="checkbox"/>	Gram Stain*	CS/O	<input type="checkbox"/>	AST	T	<input type="checkbox"/>	RPR w/reflex TPPA	T
<input type="checkbox"/>	Liquid Based PapSmear* w/HPV reflex for ASCUS	L	<input type="checkbox"/>	Group B Strep DNA Probe*	CS	<input type="checkbox"/>	Bilirubin, Direct	T	<input type="checkbox"/>	Rubella Ab	T
<input type="checkbox"/>	Liquid Based PapSmear* w/Amplified DNA CT/GC	L	<input type="checkbox"/>	Fungal Culture and Smear*	O	<input type="checkbox"/>	Bilirubin, Total	T	URINALYSIS		
<input type="checkbox"/>	HPV reflex for ASCUS	D/L	<input type="checkbox"/>	Occult Blood, Stool	O	<input type="checkbox"/>	BUN	T	<input type="checkbox"/>	Urine w/out Scope	UY
<input type="checkbox"/>	HPV regardless of results	D/L	<input type="checkbox"/>	Urine Culture*	UG	<input type="checkbox"/>	Calcium	T	<input type="checkbox"/>	Urine w/Scope no reflex	UY
STD SCREENING			<input type="checkbox"/>	Vaginal Wet Mount	O	<input type="checkbox"/>	Cholesterol, Total	T	<input type="checkbox"/>	Urine w/Scope & Culture if indicated	UY,UG
<input type="checkbox"/>	DNA probe CT/GC	GP	HEMATOLOGY			<input type="checkbox"/>	Creatinine	T	TRANSFUSION MEDICINE		
<input type="checkbox"/>	Amplified DNA CT/GC	A/L	<input type="checkbox"/>	CBC Hemogram	P	<input type="checkbox"/>	Ferritin	T	<input type="checkbox"/>	ABO Rh	R
PANELS			<input type="checkbox"/>	Hemoglobin	P	<input type="checkbox"/>	FSH	T	<input type="checkbox"/>	Ab Screen	R
<input type="checkbox"/>	Basic Metabolic Panel	T,G	<input type="checkbox"/>	Hematocrit	P	<input type="checkbox"/>	HCG, Quantitative	T	<input type="checkbox"/>	Cord Blood Panel	R,P
<input type="checkbox"/>	Comprehensive Panel	T,G	<input type="checkbox"/>	Sickle Cell Screen	P	<input type="checkbox"/>	HCG, Qualitative	U/T	TB ELIMINATION		
<input type="checkbox"/>	Hepatic Function Panel	T	DIABETIC PANELS			<input type="checkbox"/>	Iron, Total	T	<input type="checkbox"/>	LFT-4 Test	S
<input type="checkbox"/>	Lipid Panel	T	<input type="checkbox"/>	Glucose, Random	G	<input type="checkbox"/>	LH	T	<input type="checkbox"/>	LFT-6 Test	S
<input type="checkbox"/>	High Risk Panel	T,G	<input type="checkbox"/>	Glucose, Fasting	G	<input type="checkbox"/>	Potassium	T	OTHER / IN-HOUSE TESTS		
<input type="checkbox"/>	OB Panel	R,T,P	<input type="checkbox"/>	Glucose, Post Prandial	G	<input type="checkbox"/>	Prolactin	T	<input type="checkbox"/>		
<input type="checkbox"/>	OB Panel w/out CBC	R,T	<input type="checkbox"/>	Glucose, 1hr	G	<input type="checkbox"/>	Sodium	T	<input type="checkbox"/>		
<input type="checkbox"/>	Drug Screen	UY	<input type="checkbox"/>	Glucose, 2 specimens	Gx2	<input type="checkbox"/>	T3 Uptake	T	<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>	Glucose, 3 specimens	Gx3	<input type="checkbox"/>	T4 Free	T	<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>	Glucose, 4 specimens	Gx4	<input type="checkbox"/>	Triglycerides	T	<input type="checkbox"/>		
<input type="checkbox"/>						<input type="checkbox"/>	TSH	T	<input type="checkbox"/>		
<input type="checkbox"/>						<input type="checkbox"/>	Uric Acid	T	<input type="checkbox"/>		

M-47 Specimen Submission Form's Instructions

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

Section 1. SUBMITTER INFORMATION

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

Clinic Code/Submitter &, Submitter name: The submitter number is a 8 digit unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. If you do not know your clinic code please contact our customer service department.

To request a DSHS Laboratory Services Section submitter number, a master form, or to update submitter information, please call (888) 440-5002 or (210) 531-4596, or fax (210) 531-4506.

Section 2. PATIENT INFORMATION

Complete all patient information including date of collection, time of collection, contact/collected by, last name, first name, middle initial, address, city, state, zip code, telephone number, date of birth (DOB), sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis codes, and country of origin.

NOTE: The patient's name and date of birth listed on the specimen *must* match the patient's and date of birth name listed on the form **Exactly**. SSN and Medical record number are considered unique identifiers and assist the lab in identifying the correct patient from the name on file.

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. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

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 and who collected the specimen. Do not give the date the specimen was sent to DSHS. **IMPORTANT: If the Date of Collection field is not completed, the specimen may be rejected.**

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. For HIV screening, this number may be the eight-digit CDC number assigned to the patient. The CDC form sticker may be placed anywhere on the lower part of the form, as long as it does not obscure any tests ordered. CUI is the Clinic Unique Identifier number.

Contact/Collected by Information: Indicate the name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

ICD Diagnosis Code(s) and Country of Origin: Indicate the diagnosis codes 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. Ordering Physician's Information

Ordering Physician's name &, NPI Number: Give the name of the physician and the physician's NPI number. **This information is required to bill Medicaid, Medicare, and insurance.** The NPI is a 10 digit number issued by National Provider and Plan Enumeration System who is contracted by Centers for Medicare & Medicaid Services. HIPAA regulation states all healthcare providers must obtain a NPI number.

Note: The clinician name provided in section 3 will print on the patient test result page and on the monthly statistical reports.

Section 4. 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.

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 card, the submitter will be billed.
- Patient's DOB and address must be provided.

If selecting Private Insurance, Medicaid HMO, or Medicare HMO:

- 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.
- If private insurance is checked include a copy of the patient's insurance card, front and back to include the address of the insurance company. The patient must provide their signature and the current date for assignment of benefits.
- 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 Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/prog_desc.htm.
- **Do NOT check a DSHS program as a Payor Source if the patient has Medicaid, Medicare, Medicaid HMO, Medicare HMO, or private insurance.**
- For Title V, check Family Planning, Child Health, Dysplasia, or Prenatal.
- For Rio Grande State Center (RGSC), Texas Center for Infectious Disease (TCID) or Texas Infertility Prevention Program (TIPP) programs please check the appropriate box.
- The submitter will be billed for anonymous HIV testing, unless the submitter has a current contract with the HIV/STD Program and marks HIV/STD as the Payor.

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 5. CLINICAL HISTORY

Enter the date of the patient's last menstrual period (LMP). This date is necessary for patients that have a menstrual cycle. Check the boxes that are pertinent to the patient's medical history. Under narrative, provide any additional clinical history or visual findings noted during the exam.

Section 6. STD SCREEN HISTORY

Completion of this section is mandatory if the patient is participating in the Texas Infertility Prevention Project (TIPP). It's optional for parents who are not enrolled in the program.

Section 7. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. Not providing the source may affect results.

Surgical Pathology: Indicate the type of specimens(s) and site(s). Remember to include the completed colposcopy form.

TEST

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Reference Serology/Immunology" or "Virology" or "HIV/HCV Screening". For specific test instructions, see the Laboratory Services Section Manual of Reference Services.

PANELS

Basic Metabolic Panel, Comprehensive Panel, Electrolyte Panel, Hepatic Function Panel, Lipid Panel, High Risk Panel, OB Panel, OB Panel w/o CBC, Iron Panel, LFT 4 (TB Elimination), LFT6 (TB Elimination), Urine Drug Screen Panel 3, Urine Drug Screen Panel 7.

Custom Panels:

High Risk Panel

Glucose **82947**
 Cholesterol **82465**
 Triglycerides **84478**

Iron Panel

Iron, Total **83550**
 Transferrin **84466**
 Ferritin **82728**
 Transferrin Sat

OB Panel without CBC

Hepatitis B surface antigen **87340**
 Rubella antibody **86703**
 RPR **86592**
 Antibody Screen, Indirect Coombs **86850**
 ABO/Rh **86900/86901**

LFT 4 (TB Elimination)

ALT (SGPT) **84460**
 AST (SGOT) **84450**
 Bilirubin, Total **82247**
 Alk. Phosphatase **84075**

LFT 6 (TB Elimination)

ALT (SGPT) **84460**
 AST (SGOT) **84450**
 Bilirubin, Total **82247**
 Alk. Phosphatase **84075**
 BUN **84520**
 Creatinine **82565**

Legend for Specimen/Tube/Cont. Type:

Red	SST	LBP
Gray Top	Slant	Green Heparin
Yellow	Other	Urine Cup
Purple	UR Gray	UR Yellow
Serum	Cltr Swab	Digene
Biopsy	AMP-Urine	AMP-swab
Pap	M4	GProbe

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.

The M47 test requisition form is only a partial list of tests available. If you require a test that is not listed on the requisition form or need an electronic copy of this form filled out with your clinic code and address please call 888-440-5002 / 210-531-4596.

For specific test instructions and information about tube types, refer to WHL Start-Up Packet or call our Customer Service Department.