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

P.(956) 364-8746 F.(956) 412-8794

F40-A-Specimen Submission Form (Jan 2022)

CLIA #45D0503753 CAP #2148801

www.dshs.texas.gov/lab/so_tx_lab

Place DSHS Bar Code Label / Address-O-Graph 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 **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
DOB (mm/dd/yyyy) **	Sex **	Unique Number / 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)

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Date of Onset (mm/dd/yyyy)	Diagnosis / Symptoms	Risk

Section 3. ORDERING PHYSICIAN INFORMATION -- (** REQUIRED)

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

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 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) ☐ Private Insurance (4)
☐ HIV / STD (1608) ☐ Other: _____
☐ OPC

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 5. CHEM PANELS

- ☐ Basic Metabolic Panel ♥
- ☐ Comp Metabolic Panel ♥
- ☐ Electrolytes Panel
- ☐ Hepatic Function Panel
- ☐ Lipid Profile Panel ♥
- ☐ Renal Function Panel
- ☐ **TB Panel:** (ALT); (AST); (Alk Phos); Billi, T); (BUN); (Chol); (Creat); (GGT); (Uric Acid)

Section 6. CHEMISTRY

- ☐ Albumin
- ☐ Alkaline Phosphatase
- ☐ ALT {SGPT}
- ☐ Amylase
- ☐ AST {SGOT}
- ☐ Bilirubin, Direct
- ☐ Bilirubin, Total
- ☐ Bilirubin, total & direct profile
- ☐ Blood Urea Nitrogen (BUN)
- ☐ Calcium
- ☐ Carbon dioxide (CO2)
- ☐ Chloride
- ☐ Cholesterol, Total
- ☐ Cholesterol HDL
- ☐ Cholesterol LDL
- ☐ Creatine kinase (CK)
- ☐ Creatinine
- ☐ GGT
- ☐ Glucose
- ☐ **Glucose 2 Hr PP**
- ☐ **Hemoglobin A1C**
- ☐ Iron, Total
- ☐ Iron Binding Capacity, Total (TIBC)
- ☐ **Lactic Acid Dehydrogenase (LDH)**
- ☐ Lipase
- ☐ Magnesium
- ☐ Phosphorus
- ☐ Potassium
- ☐ Protein, Total
- ☐ **Sodium**
- ☐ Triglycerides
- ☐ **Uric Acid**

Section 7. URINALYSIS

- ☐ Urine Micro Albumin Random
- ☐ Urinalysis *
- ☐ Microscopy with Urinalysis (UA)

Section 8. HEMATOLOGY

- ☐ CBC automated with differential *
- ☐ Differential, Manual
- ☐ Hematocrit
- ☐ Hemoglobin, Total
- ☐ Peripheral Smear Review
- ☐ Sedimentation Rate (ESR)

Section 9. SPECIAL CHEMISTRY

- ☐ Ferritin
- ☐ FSH
- ☐ LH
- ☐ Prolactin
- ☐ PSA, Total
- ☐ Thyroid stimulating hormone (TSH)
- ☐ Thyroxine (T4), free
- ☐ Thyroxine (T4), Total
- ☐ Thyroid Hormone (T3) Uptake
- ☐ Tri-iodothyronine (T3), free

NOTES: ♥ = Fasting preferred for test.
▲= Document **time & date** specimens were **removed from REEZER/REFRIGERATOR** in the lower right-hand box

*additional testing procedures will be ordered as reflex testing if clinically indicated.

▲ **REQUIRED for cold/frozen shipments, if stored in an appliance.**

Indicate removal from: ☐FREEZER ☐REFRIGERATOR	DATE	TIME

FOR LABORATORY USE ONLY Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen