



TEXAS Health and Human Services

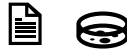
Texas Department of State Health Services

CAP# 3024401

CLIA #45D0660644

Questions? LabInfo@dshs.texas.gov Specimen Acquisition: (512) 776-7598

Remember 1-1



1 FORM = 1 SAMPLE

Please complete a separate form for each specimen submitted

SPECIMEN BARCODE
This Space for DSHS Laboratory Use Only

G-2A Specimen Submission Form

SECTION 1. SUBMITTER
** REQUIRED
Submitter/TPI Number ** Submitter Name**
NPI Number ** Address **
City ** State ** Zip Code **
Phone Number ** Fax ** Contact Name and/or Email Address

SECTION 2. PATIENT
NOTE: Patient name on specimen MUST match name on this form exactly.
Name mismatches will be rejected.
Specimen container must have two (2) unique identifiers that match this form exactly.
Last Name ** First Name ** MI
Address ** Phone Number
City ** State ** Zip Code ** Pregnant?
DOB (mm/dd/yyyy) ** Sex** Ethnicity:
Race:
Diagnosis / Symptoms
Date of Onset
ICD Diagnosis Code

SECTION 3. SPECIMEN
NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.
Date of Collection (mm/dd/yyyy) ** Time of Collection **
Unique Identification Number **
Specimen Source or Type (Select One Only) **
Indicate REMOVAL from:
FREEZER REFRIGERATOR

SECTION 4. HIV/STD TESTING
HIV Screen Syphilis Screen
Justification Required:
Monitoring Treatment (Plasma) Assessing Perinatal Exposure
Treatment Follow-up (must be same method as baseline RPR)
Confirmation of positive POC test results

SECTION 5. HEPATITIS TESTING
Hepatitis A, B, C, E
Hepatitis Surface Antibody
Hepatitis Surface Antigen
Hepatitis C Antibody
Hepatitis C RNA, Quantitative NAAT Only

SECTION 6. SEROLOGICAL REFERENCE TESTING
Brucella, Total Antibody
Chagas IgG
Hantavirus IgM & IgG
Measles IgM
Measles IgG
Mumps IgG
Rocky Mountain Spotted Fever & Typhus Fever Panel IgG
Rubella IgG
Schistosoma IgG
Strongyloides IgG

SECTION 8. ORDERING PHYSICIAN
** REQUIRED
Physician's NPI Number** Physician's Name**

SECTION 9. PAYOR SOURCE
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 Advance Beneficiary Notice (ABN) requirements.

** REQUIRED
Medicaid (2) Medicare (8)
Medicaid/Medicare #:
Submitter (3)
BIDS (1720)
Pub Hlth Follow Up (1608)
HIV Prevention (1611)
Immunizations (1609)
Private Insurance* (4)
TB Elimination (1619)
IDEAS/EAIDU (1610)
Zoonosis (1620)
Other:

HMO / Managed Care / Insurance Company Name *
Address *
City * State * Zip Code *
Responsible Party / Subscriber *
Insurance Phone Number * Insurance ID Number *
Group Name Group Number
Signature of Patient or Responsible Party
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, Public Health Laboratory Division.

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