

CT Lung Cancer Screening Program Form

PATIENT INFORMATION (ALL fields are required)

Name: _____ Date of Birth _____
Address: _____ City _____ State: _____ Zip _____
Contact Phone Number: _____

Primary Insurance _____ Subscriber
ID: _____

PLEASE INDICATE THE TYPE OF EXAM:

- A. Initial Screening Exam (CPT 71271)
- B. Subsequent Annual Screening Exam (CPT 71271)
- C. Follow up Diagnostic CT Chest without contrast (CPT 71250)

****Imaging Schedulers: If A or B is checked, schedule exam as "CT Chest Low Dose" if option C, schedule as "CT Chest Follow up Diagnostic"*

PATIENTS MUST MEET ALL OF THE FOLLOWING CRITERIA FOR LOW DOSE CT SCREENING (PLEASE CHECK ALL BOXES):

Age 50-77 (Medicare/Medicare Advantage)
Age 50-80 (Commercial/Private Insurances, Medicaid/Medicaid Managed)
20+ pack year smoking history: _____ pack years (please estimate to closest whole number)

Age started smoking: _____
How many packs per day? _____

Packs per day x Years smoked = Pack Years
example: 2 packs per day X 10 years = 20 pack years;
1 pack per day x 20 years = 20 pack years; pack per day x 40 years = 20 pack years)

Current Smoker: _____
Former Smoker: _____

Year Quit: _____ (*Must be within the last 15 years*)
Asymptomatic for Lung Cancer
Lung Cancer Screening Shared Decision-Making visit (Code G0296) documented & billed

G0296 required only for initial lung cancer screening (option A above)

Clinical Indication: CT Lung Screening (Low Dose CT)
ICD-10 Code for Imaging Study (ONLY CHECK ONE)
Z87.891 Personal History of nicotine dependence
F17.210 Nicotine dependence, cigarettes, uncomplicated
F17.211 Nicotine dependence, cigarettes, in remission

Insurance Authorization Number _____ Auth
Expiration _____

Please indicate "No Authorization required" if applicable
Date _____ Time _____