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; ½ 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_____