# CT Lung Screening Order Form

**For insurance submission, screening criteria* and completed form are required.**

Patient Name:_____ MRN:_____ DOB:____/____/____

Ordering MD (print name) _____ Phone:_____

PHYSICIAN Signature:_____ Date:___ /__ /__

Insurance Carrier_____ Insurance Policy NO/Member ID_____

Insurance Group NO_____ Insurance Contact Person Telephone_____

Pre Auth #_____ ☐ **SELF PAY $215.00**

***Screening Criteria:** Current smoker or former smoker, age 55-77, who has quit in the past 15 years and a smoking history of at least 30 pack years. A 30 pack year is defined as: One pack a day for 30 years or two packs a day for 15 years.*

Billing/Diagnosis Codes

**Note: if patient is not Medicare please fax copy of insurance with script**

☐ ICD10 Diagnosis Code ZB7.891 Personal History of Nicotine Dependence (for Medicare)

☐ ICD10 Diagnosis Code Z12.2 Special Screening for malignant neoplasm

**Patient must meet all criteria to qualify for screening.**

☐ 55-77 years of age patient age_____

☐ Asymptomatic (no signs or symptoms of new lung disease or symptoms of lung cancer)

☐ Tobacco smoking history of at least 30 pack-years (one pack-year=smoking one pack per day for one year, 1 pack = 20 cigarettes)

# of packs per day____ **X** # of years smoking _____=_____pack year history

**Pack year calculator at: http://smokingpackyears.com/**

☐ Current smoker or one who has quit smoking within the last 15 years

Date patient quit smoking: Month_____Year_____

☐ **Medicare patients only**: For the initial LDCT lung cancer screening service, a lung cancer screening counseling and shared decision making visit has been completed by ordering physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) (G-code: G0296)


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