CT LUNG CANCER SCREENING ORDER FORM

Questions regarding eligibility, please call the Imaging Department Patient Coordinator: (310) 248-7523. Please fax this form to: (310) 423-5684. We must receive this order prior to scheduling.

<table>
<thead>
<tr>
<th>PATIENT LEGAL NAME:</th>
<th>DATE OF BIRTH:</th>
<th>PATIENT TELEPHONE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSURANCE NAME:</td>
<td>MEMBER/POLICY ID #:</td>
<td>PREAUTHORIZATION #:</td>
</tr>
<tr>
<td>PROVIDER NAME:</td>
<td>PROVIDER TELEPHONE:</td>
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</tbody>
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**Option 1:** Provider-managed CT Lung Cancer Screening:

Provider will need to confirm patient’s eligibility, as well as perform and document a counseling and shared decision-making visit. Scheduling follow-up studies and visits, including for incidental findings, and communication with the patient will be done by the ordering provider.

Please choose the appropriate exam:

**CT Chest Lung Cancer Screening** (Baseline or Annual Exam) CPT 71271

- ☐ Baseline
- ☐ Annual

**ICD-10 code:**

- ☐ Z87.891 Personal history of tobacco use/personal history of nicotine dependence
- ☐ F17.210 Nicotine dependence, cigarettes, uncomplicated

**CMS Eligibility Criteria:**

- Is the patient age 50-77?  ☐ Yes  ☐ No  (Other insurers may cover patients outside this age range)
- Does the patient show any signs or symptoms of lung cancer?  ☐ Yes  ☐ No
- Is the patient a current smoker or quit within the past 15 years?  ☐ Yes  ☐ No
- What is the patient’s total pack-years (avg. number of packs per day x total years smoked)? __________
- Is there documentation of shared decision-making?  ☐ Yes  ☐ No
- Did the patient receive smoking cessation guidance?  ☐ Yes  ☐ No
- Has the patient had a CT Chest exam within the past 12 months?  ☐ Yes  ☐ No

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**Option 2:** Follow-up of a finding from prior CT Lung Cancer Screening:

- ☐ CT Chest Lung Cancer Screening Follow-Up CPT 71250

Reason for exam/Follow-up: ____________________________________________________________

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**Option 3:** Refer to Lung Cancer Screening Program:

Patient will be contacted by a nurse navigator, screened for eligibility, and scheduled for a counseling and shared decision-making visit. All follow-up studies and visits, including for incidental findings, will be arranged and communicated with the patient and referring provider.

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**Provider Signature and Contacts:**

<table>
<thead>
<tr>
<th>Provider Signature:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Call Results:</td>
<td>Provider contact number: ________________________________</td>
<td></td>
</tr>
<tr>
<td>☐ Fax Results:</td>
<td>Provider fax number: ________________________________</td>
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A Lung Cancer Screening Program
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8705 Gracie Allen Dr
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