UofL Health | Brown Cancer Center

LDCT Lung Cancer Screening Order Form

Prior Auth #: _____ Start date: _____ Exp date: _____

Name: _____ DOB: _____ Age:_____ (must be 50-80)

Phone#: _____ Cell#: _____ Gender_____ Ht: ____ Wt: ____

Address: _____ City: _____ Zip: _____

Insurance Carrier: _____ Member ID#: _____

Subscriber Name (if different from patient): _____ Subscriber DOB: _____

****Has the patient had a CT chest (excluding CTA) within the last 12 months? Yes _____ No _____**

CT Screening Procedure Code: 71271 Diagnostic code _____ Baseline OR Annual (Circle one)

Per ACR, Medicare will deny G0296 and 71271 for claims that do not contain these ICD-10 diagnosis codes Z87.891 for former smokers (personal history of nicotine dependence) and F17.21_?_ for current smokers (nicotine dependence) (https://www.acr.org/Clinical-Resources/Lung-Cancer-Screening-Resources/FAQ)

Smoking History: Current _____ Former _____ If former, # years since quitting (must be <15 years): _____

Total # years smoked: _____ X # packs per day: _____ = Pack-year total: _____ (must be ≥20 pk-yrs.)

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Date: _____ Ordering Provider's Name: _____

Office Phone: _____ Office Fax: _____

Louisville area locations: ____UofL Hosp. ____Jewish Hosp. Downtown ____ Med. Ctr. East ____ Med. Ctr. NE
____ Med. Ctr. South _____ Mary & Eliz. Hosp ____ Med. Ctr. SW ____ Shelbyville

By signing this order, you are certifying that:

- **The patient has participated in a shared decision-making session during which potential risks and benefits of CT lung screening were discussed.**
- **The patient was informed of the importance of adherence to annual screening, impact of comorbidities, and has indicated the ability/willingness to undergo diagnosis and treatment.**
- **The patient was informed of the importance of smoking cessation and/or maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable.**
- **The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss**

Physician Signature: _____ Date: ___/___/____

Physician NPI: _____

Please fax this signed /dated order to Cancer Screening Services: 502-210-4475

Appointment Date: _____/_____/_____ M T W TH F S Appointment Time: _____