Cedars Sinai

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.

PATIENT LEGAL NAME:	DATE OF BIRTH:	PATIENT TELEPHONE:
INSURANCE NAME:	MEMBER/POLICY ID #:	PREAUTHORIZATION #:
PROVIDER NAME:		PROVIDER TELEPHONE:

☐ **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 × 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

→ *Proceed to signature section at the bottom.*

☐ **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: _____

_____

→ *Proceed to signature section at the bottom.*

☐ **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.

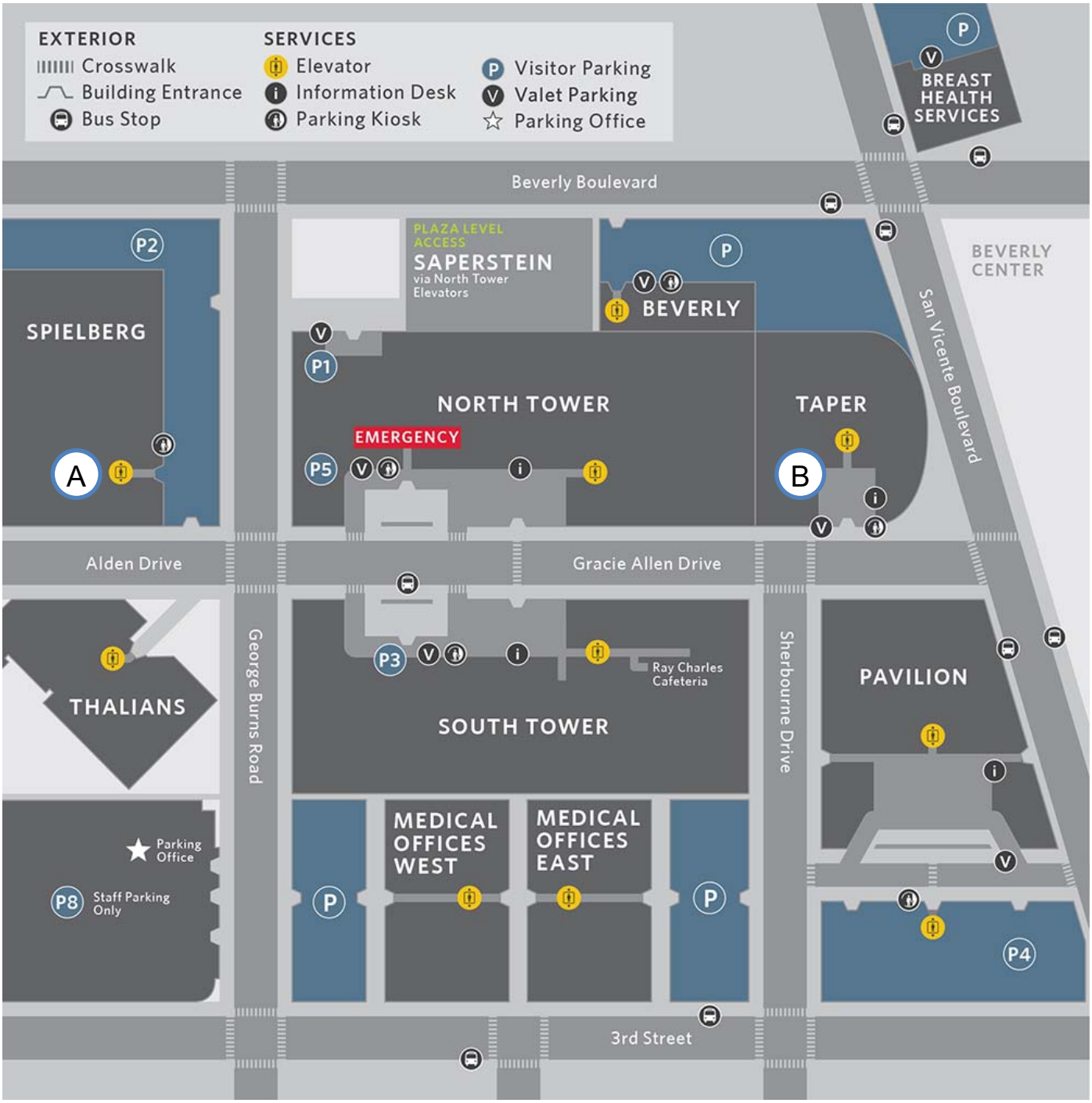
→ *Proceed to signature section at the bottom.*

Provider Signature and Contacts:

Provider Signature: _____ Date: _____ Time: _____

☐ Call Results: Provider contact number: _____

☐ Fax Results: Provider fax number: _____



A Lung Cancer Screening Program
Spielberg Building
8723 Alden Dr, Suite 260
Los Angeles, CA 90048

B S. Mark Taper Foundation Imaging Center
8705 Gracie Allen Dr
Los Angeles, CA 90048