McLaren NORTHERN MICHIGAN

COMPUTED TOMOGRAPHY (CT) LUNG CANCER SCREENING ORDER

Please fill out each section and fax to Central Scheduling as listed below

Patient's Legal Last Name ____ First Name ____ Middle ____ Medical Record Number ____

Date of Birth ____ Age ____ Height (inches) ____ Weight (lbs.) ____ Location: ☐ Cheboygan ☐ Petoskey

Procedure (select one):
- ☐ Initial Lung Screening Low Dose CT – 71271
- ☐ Lung Screening Diagnostic Eval (3 or 6 Month Follow-up) Low Dose CT (CT Chest without Contrast) - 71250 (Only order if recommended by prior LDCT report: Lung -RADS 3 or 4A. Screening criteria not applicable)
- ☐ Annual Lung Screening Low Dose CT – 71271

Primary Insurance Provider

SELECT RELEVANT ICD-10 DIAGNOSIS (CODES)

GOVERNMENT PAYERS
- ☐ F17.210: Nicotine dependence, cigarettes, uncomplicated
- ☐ F17.211: Nicotine dependence, cigarettes, in remission
- ☐ F17.213 Nicotine dependence, cigarettes, w/withdrawal
- ☐ F17.219: Nicotine dependence, cigarettes, w/other nicotine induced disorders
- ☐ F17.218 Nicotine dependence, cigarettes, w/unspecified nicotine-induced disorders
- ☐ Z87.891 Personal history of nicotine dependence

ALL OTHER PAYORS
- ☐ F17.210: Nicotine dependence, cigarettes, uncomplicated
- ☐ F17.211: Nicotine dependence, cigarettes, in remission
- ☐ F17.213: Nicotine dependence, cigarettes, w/withdrawal
- ☐ F17.218: Nicotine dependence, cigarettes, w/other nicotine-induced disorders
- ☐ F17.219: Nicotine dependence, cigarettes, w/unspecified nicotine-induced disorders
- ☐ Z72.0 Tobacco use (no dependence, social smoker, occasional use of tobacco)
- ☐ Z12.2: Encounter for screening for malignant neoplasms of respiratory organs
- ☐ Z87.891: Personal history of nicotine dependence

CMS BENEFICIARY ELIGIBILITY CRITERIA

Must meet ALL four criteria:

☐ Age 50-77 years

☐ Tobacco smoking history of at least 20 pack years (pack=20 cigarettes)

_____ packs per day x _____number of years smoked = _____ pack years

☐ Asymptomatic, no signs or symptoms of lung cancer

(NO symptoms, such as: fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss.)

☐ Current Smoker or one who has quit smoking within the last 15 years
Currently smoking? ☐ YES ☐ NO
If not smoking, date Quit _______

History of Lung Cancer: ☐ YES ☐ NO

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 ability/willingness to undergo diagnosis and treatment.
- The patient was informed of the importance of smoking cessation and/or maintain 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).

Ordering Provider Signature:________________________________Date:___________________Time:_______________

Ordering Provider Printed Name:____NPI#:________________________

Practice Name:_______________________________________ Address:_______________________________________

Phone Number:_______________________________________ Fax Number:____________________________________

Please complete, print, sign and fax to Central Scheduling: Fax 231-487-7920 | Phone toll free 866-487-3103

MNM 721.297

R(2/16/2022)