CULLMAN REGIONAL

1912 Alabama Highway 157
Cullman, AL 35058
Scheduling: (256) 737-2667
Scheduling FAX: (256) 737-2010
Pre-Authorization: (256) 737-2175
Pre-Authorization FAX: (256) 737-2176
Questions? (256) 737-2180

LUNG SCREENING ORDER FORM*

**In order to meet Federal billing guidelines, the following information must be obtained prior to completion of the exam. Please ensure all mandatory fields are completed prior to patient arrive to CT appointment.*

Patient Name: _____ **Patient SSN#:** _____

Patient Date of Birth: _____ **Patient Phone Number:** _____ **Sex:** *(circle one)* MALE FEMALE

Patient must be between the age of 55-77 for Medicare or 55-80 for most private insurance carriers.

Patient Height: _____ feet _____ inches **Patient Weight:** _____ pounds

Currently Smoking? *(circle one)* YES NO

Packs/day(20/pack): _____ x **Years Smoked:** _____ = **Pack years:** _____

If no, how many years since you quit? _____ **What type of nicotine dependency?** _____

Does this patient exhibit any signs or symptoms consistent with Lung Cancer? ☐ NO ☐ Yes - if yes, we recommend a CT Thorax w/contrast, not this study.

Exam to be completed: CT Low Dose Lung Screening *(select a CPT code below)*

☐ **Z12.2 Screening*** Required for all Low Dose CT Screening Tests **CPT Code:** G0297

Indication: Lung Cancer Screening (select one) ☐ Initial ☐ Follow-up

Diagnosis: *(select one below)*

☐ **DX: Z87.891 Personal History of Tobacco Use or Nicotine Dependence (Former Smoker)**

☐ **F17.210 Personal History of Tobacco Use or Nicotine Dependence (Current Smoker)**

By signing this order, you certify that the patient:

- Has participated in a shared decision-making session during which potential risk and benefits of lung screening were discussed.
- Was informed of the importance of adherence to annual screening, impact of co-morbidities, and ability/willingness to undergo diagnosis and treatment
- Was informed of the importance of smoking cessation and/or maintaining smoking abstinence, including the offer of tobacco cessation / tobacco treatment counseling services.

Ordering Provider Name (printed): _____ NPI Number: _____

Ordering Provider Signature (required): _____ Date/Time: _____

Provider Office Telephone: _____ Provider Office FAX Number: _____

Additional reports should be sent to: _____