McLaren
GREATER LANSING

Submit

CT Lung Screening Order Form

Patient Name: _____ Phone Number: _____ DOB: ____/____/____

Packs/day (20 cigarettes/pack): _____ x years smoked: _____ = pack years*: _____
(Must be greater than or equal to 30 years)

Dx: Currently smoking cigarettes? ☐ Y ☐ N If "no," how many years since you quit? _____
(Must be less than or equal to 15 years)

Height: _____ Weight: _____ SSN: _____

Ordering Physician (print name) : _____ Phone: _____

National Provider Identifier (NPI) : _____ Fax: _____

☐ CT Lung Screening Exam for Lung Cancer ***(Hospital coders: Code Z12.2, plus add smoking status code)***

☐ *Initial* ☐ *Repeat*

Please obtain prior authorization for insurances other than straight Medicare
"Low dose CT for lung cancer screening" - ***Please use the G code: G0297 (managed Medicare plans, plus others)***

Authorization Number: _____

Please include a demographic sheet and fax to (517) 975-3060.
Call (517) 975-8030 with any questions.

By signing this order, I certify that:

- The patient is between the ages of 55 and 77.
- 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/wilingness 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 conseling 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 Physician Signature: _____ Date: _____ Time: _____

Via (Office Staff): _____

Corresponding visit ID Number: _____

****The above named ordering physician hereby authorizes this electronic signature for this exam as evidenced by their physical signature contained in the above referenced visit ID number.***

****The above named ordering physician understands all forms sent containing PHI must be encrypted and the burden of encryption falls on the sender.***