

ONCOLOGY SPECIALISTS
OF CHARLOTTE

A Partner of  OneOncology

CT LUNG SCREENING ORDER FORM

Patient Name: _____ DOB: ____ / ____ / ____ Patient Phone#: _____
Address: _____
Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = **Pack years***: _____
Currently smoking? YES NO If not currently smoking, how many years since stopped? _____

DIAGNOSIS CODE

Smoker Z72.0

Former Smoker Z87.891

CT LUNG SCREENING EXAM (Please select one)

CT Initial Lung Screening
(Technical Imaging Services Only)

CT Lung Follow-Up Screening
(Technical Imaging Services Only)

***PLEASE AUTHORIZE FOR ONE OF THE FOLLOWING CODES:**

G0297 CT LOW DOSE LUNG SCREENING OR 71250 CT THORAX WITHOUT CONTRAST

NPI#: 14674406736 **TIN#:** 56-2179043

AUTHORIZATION #: _____

****OSC will not be providing any professional services in connection with the selected screening. Results will be sent to the referring provider for interpretation and professional follow-up.**

WE WILL NEED THIS FROM YOU BEFORE SCHEDULING

HOW WOULD YOU LIKE RESULTS

FAX Please provide fax #: _____

EMAIL Please provide email address: _____

FAX THIS FORM ALONG WITH DEMOS AND INSURANCE CARD FAX#: 704.377.0353

FOR OFFICE USE

<input type="checkbox"/> I have confirmed the patient meets all eligibility criteria listed below, offered smoking cessation counseling & a shared decision visit occurred.	<input type="checkbox"/> Age 50-80 years *Insurance coverage may vary, CMS covers age 50-77.
<input type="checkbox"/> No signs or symptoms of lung cancer.	<input type="checkbox"/> Tobacco smoking history of at least 20 pack-years. Number pack-year smoked
<input type="checkbox"/> Current smoker or quit smoking within the last 15 years Number of years since quitting _____	<input type="checkbox"/> Patient has not had a chest CT scan in the past year.

CHARLOTTE
2711 Randolph, Road, Suite 400
Charlotte, NC 28207

DISCOVER THE
DIFFERENCE
IN CANCER CARE

Ph: 704.342.9577
Fax: 704.377.0353
charlotte**CAN**cer.com