



(Place Patient Identification Sticker Here)

Low Dose CT Lung Cancer Screening Order

Patient Name: _____ DOB ____/____/____

Ordering MD, NP, or PA (print): _____ NPI #: _____

The patient must answer “yes” to the following criteria to be eligible for Medicare Coverage (please fill out all spaces):

- ☐ Between age of 50 – 77
- ☐ Tobacco smoking history of at least 20 pack – years?
- ☐ Current smoker or one who has quit smoking within the last 15 years?
If former smoker, what year did the patient quit? _____
Packs per day (20 cigarettes/pack): _____ x years smoked _____ = pack years _____
- ☐ Asymptomatic? (no signs or symptoms of lung cancer)

The patient has participated in a lung cancer screening counseling and shared decision making visit, furnished by a MD, PA, NP or clinical nurse specialist who covered the following:

- ☐ Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow – up diagnostic testing, over – diagnosis, false positive rate and total radiation exposure.
- ☐ Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment.
- ☐ Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation intervention.

In order to bill Medicare, all the above criteria must be met. Non – Medicare patients can still have the lung cancer screening CT performed and their insurance company will be billed. If insurance does not cover this screening CT, the cost of the test will be an out – of – pocket expense for the patient.

By signing this order, I am certifying that all requirements above have been met.

Authorizing Signature: _____ Date: _____ Time: _____

