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	
☐I have confirmed the patient meets all eligibility criteria listed below, offered smoking cessation counseling & a shared decision visit occurred.	☐ Age 50-80 years *Insurance coverage may vary, CMS covers age 50-77.
☐ No signs or symptoms of lung cancer.	☐ Tobacco smoking history of at least 20 pack-years. Number pack-year smoked
☐ Current smoker or quit smoking within the last 15 years Number of years since quitting_____	☐ 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