KentuckyOne Health® Cancer Care

Cancer Prevention Services
855.34KYONE (855.345.9663)

Date of Call: _____ Prior Auth #: _____

Name: _____ DOB: _____ Age: _____ (55-80*) Phone #: _____

Address: _____ City: _____ Zip: _____

Gender: M F SS#:_____ Height: _____ Weight: _____

(MC only) Date of **Shared Decision Making** counseling office visit: ____/____/_____ Completed by: _____

Did Provider offer **smoking cessation counseling and resources**? **Yes** **No** **Unnecessary**

_____ Insurance: ***Commercial insurances cover ages: 55 - 80 (Aetna: 55 – 79); Medicare covers ages: 55 – 77**

Insurance Carrier: _____ Member ID#: _____

Group #_____ Ins. Phone #: _____

Subscriber Name (if different from patient): _____ Subscriber DOB: _____

_____ How patient heard about CTLS program: TV, Mailing, Radio, PCP, Pulmonologist, Other Specialist, Newspaper, Friend)?

Race (Caucasian, African Am, Asian, etc.):_____ **Ethnicity** (Hispanic or non-Hispanic):_____

Exclusion Criteria: 1. Has patient had a regular chest CT within the last 12 months? Yes _____ No _____

2. Does patient have lung cancer or any symptoms of lung cancer? Yes _____ No _____

CT Screening Hx: Is this the first (Baseline) CT Screening? Yes ____ No ____ **OR** Annual Screening? Yes ____ No ____

Smoking History: Current _____ Former _____ Age when first started _____ Total number of years smoking: _____

Number of packs per day: _____ Number of years since quitting (**must be <15 years**): _____

Pack-year total*: _____ (**must be ≥30 pk-yrs.** *Pack-year = # years smoked multiplied by # packs per day)

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Date: _____ **Physician Order - Low Dose CT for Lung Cancer Screening**

Ordering PCP's Name: _____

Office Phone: _____ **Office Fax: _____**

L'ville locations: _____U of L'ville _____Jewish Hosp. Downtown _____ Med. Ctr. Jewish East

_____ Med. Ctr. Jewish NE _____ Med. Ctr. Jewish South _____ ST Mary & Eliz. Hosp. _____ Med. Ctr. Jewish SW

Eastern/Central KY: _____ (St Joe) Bluegrass Regional Imaging–East _____ (St Joe) Bluegrass Regional Imaging–West

_____ Jewish Hosp. Shelbyville _____ Flaget (Bardstown) _____St J. Jessamine (Nicholasville)

_____St J. Richmond _____St. J. London Hosp. _____ London Imaging Ctr. _____ St J. Martin

Appointment Date: _____/_____/_____ M T W TH F S Appointment Time: _____

Physician Signature: _____ Date: ____/____/____

Diagnosis Codes: **ICD-9 Codes** (*for dates of service on or before Sept 30, 2015):*
V76.0 (Special screening for malignant neoplasms of respiratory organs); **V15.82** (History of tobacco use);
ICD-10 Codes (***for dates of service on or after October 1, 2015***):
Z87.891 Personal history-nicotine dependence; **F17.210** Nicotine dependence, cigarettes, uncomplicated; **Z72.0** Tobacco use

Procedure Code: **HCPCS S-8032** Low-dose computed tomography for lung cancer screening

Please fax this signed /dated order to Cancer Prevention Services

502-210-4475

Upon receipt of the signed / dated order, our Oncology Patient Coordinators will schedule this exam.