Delaware Cancer Treatment Program
General Prior Authorization Form

Delaware Cancer Treatment Program
Division of Public Health
C/O Gainwell Technologies
P.O. Box 909 Manor Branch
New Castle, DE 19720-0950

Prior Authorization for the following Delaware Cancer Treatment Program (DCTP) procedure is requested as follows:

PLEASE COMPLETE ALL FIELDS

DCTP-Eligible Client:_____ Client ID Number: _____

Diagnosis: _____

Procedure to Be Performed, HCPC Code(s): _____

From Date of Service: _____ To Date of Service: _____

Medical

Instructions: Complete all relevant fields.

Procedure to Be Performed, HCPC Code(s): _____

Modifier (If Applicable) _____ Revenue Code (If Applicable):_____ Number of Units:_____

Additional Remarks:_____

_____

Dental

Instructions: Complete all relevant fields. Requests for Periodontics and Prosthodontics also require submission of X-rays.

Procedure to Be Performed (CDT Code): _____

Modifier (If Applicable):_____ Related Tooth/Quadrant/Arch: _____

Missing Teeth:_____ Fee: _____ Number of Units: _____

Additional Remarks: _____

I understand that the service must be medically necessary and directly related to the treatment plan in order for this request to be approved and that DCTP does not reimburse any services related to cancer surveillance. I also understand that the client must be DCTP-eligible on the date the service is performed, in order to be paid by the Delaware Cancer Treatment Program.

Provider Name:_____ Date: _____

Provider Billing MCD ID (Not NPI)_____ Provider Phone:_____ Provider Fax: _____

Please fax to **1-302-454-7603**, to the attention of the Delaware Cancer Treatment Program, or mail to:

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