



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Prior Authorization Request Form

General Instructions

- Prior Authorization requests **must be submitted electronically** via the DMAP Provider Portal to start the PA process.
- Submit all requests 2 weeks prior to scheduled date of service.**
- Incomplete forms may delay the authorization process.
- Documentation related to the service(s) requested should be sent with the request.

For questions, contact Provider Services at 800-999-3371.

Date Received: _____

FFS Eligibility Effective Date: _____

The Delaware Medical Assistance Program manuals are available for instructions and form downloads at <https://medicaid.dhss.delaware.gov/>

A. MEMBER INFORMATION

Name:	Member ID:	D.O.B.:
Address:	Phone:	

Other Health Insurance (OHI) Information

Name of OHI:	Policy #:
Policyholder Name:	Policyholder SSN:

B. ORDERING PROVIDER INFORMATION

Name:	FAX #:
Address:	
Person Completing Form:	Telephone #:
NPI (National Provider ID) + Taxonomy:	

C. PRIMARY PHYSICIAN INFORMATION

Name:	FAX #:
NPI (National Provider ID) + Taxonomy:	Telephone #:

D. DME / HHC INFORMATION

Name:	Telephone #:
NPI (National Provider ID) + Taxonomy:	

E. SERVICE INFORMATION

Service Dates: FROM:	TO:	Continuation of Service ☐ Yes ☐ No
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Diagnosis(es) / Service(s) / Procedure(s)

Diagnosis(es) ICD-10:				
CPT® / HCPCS Codes:				

F. PLACE OF SERVICE:

Out of State Provider: Yes ☐ No ☐

Name:	Telephone #:
NPI (National Provider ID) + Taxonomy:	FAX #:

CHECK SERVICES REQUESTED

- | | | |
|--|---|--|
| ☐ Durable Medical Equipment (DME) | ☐ Surgery / Diagnostic Testing / Other | ☐ Home Health Care (HHC) Service(s) – Please specify |
| ☐ Private Duty Nursing | ☐ Skilled Nursing Visits | ☐ Home Health Aid (if greater than two hours per day) |
| ☐ Physical Therapy | ☐ Occupational Therapy | ☐ Speech Therapy |

Comments:

DO NOT WRITE BELOW THIS LINE

Date Received:	☐ Approved ☐ Denied ☐ Incomplete	Authorization #:
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Comments:

Signature:	Date:
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