Delaware Cancer Treatment Program
Certificate of Cancer Diagnosis
Medical Referral

Facility/Clinic: ____

Client Name: ____ SSN: _________________________

Cancer Diagnosis Code: ____

• The date of cancer diagnosis will be considered the date cancer treatment is initiated and will be the eligibility start date for the Delaware Cancer Treatment Program.

• If cancer treatment will not be initiated until a later date, please indicate below the date cancer treatment will begin, in addition to the diagnosis date. Eligibility in the DCTP will begin on this cancer treatment start date.

• Please enter the cancer diagnosis code and include the fourth/fifth digit of specificity. A three digit diagnosis code will not be accepted when a more specific code is available.

• The client must need treatment for cancer in the opinion of the applicant's licensed physician of record. Cancer treatment will not include routine monitoring for pre-cancerous conditions, or monitoring for recurrence during or after remission.

Diagnosis Date: _____/_____/_____ **Treatment Start Date:** _____/_____/_____

MM DD YYYY MM DD YYYY

___________________________________ ___________________________________ ________________

Physician Signature Date Physician Printed Name Phone Number

Please send the original certificate with the physician's signature and a completed DCTP Application.
Prescriptions for the treatment of cancer may require a Cancer Diagnosis written on them.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Delaware Cancer Treatment Program
Division of Public Health
c/o HPES
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