



Department of Health & Social Services
Division of Public Health

Delaware Cancer Treatment Program General Prior Authorization Form

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

Medical

Instructions: Complete all fields.

DCTP-Eligible Client: _____ Client ID Number: _____

Diagnosis: _____

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

Tentative Treatment Date: _____ Additional Remarks: _____

Dental

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

DCTP-Eligible Client: _____ Client ID Number: _____

Diagnosis: _____

Procedure to Be Performed (CDT Code) _____

Tentative Treatment Date: _____ Related Tooth/Quadrant/Arch: _____

Missing Teeth: _____ Fee: _____

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. 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 ID Number _____ Provider Phone: _____ Provider Fax: _____

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

Delaware Cancer Treatment Program
c/o HPES
PO Box 909 Manor Branch
New Castle, DE 19720