



**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 Cancer Treatment Program
Division of Public Health
c/o EDS
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New Castle, DE 19720-0950