



DC Department of Health Care Finance Request for Determination of Coverage and Pricing

Email this form as an attachment to DHCFCoverageTeam@dc.gov.

If this request is in relation to a life-threatening condition, do not use this form. Please call 202-724-8936

Requestor Information

Contact name/Title: _____ Date: _____

Organization: _____ Phone: () _____

Email: _____

CPT/ HCPCS/NDC (List one per form): _____

Request: Coverage Units Price Prior authorization Other

Specialties and sub-specialties that perform the service:

Site of service:

Diagnosis/Condition for treatment:

Clinical vignette:

Rationale: Include background information and peer-reviewed clinical evidence including sources and full text articles. Information should include evidence for efficacy, safety, and clinical appropriateness. For medication include strength, dose, and dosage form. (Use attachment as needed.)

Ownership/Financial disclosure forms applicable: [] Yes, attachment included. [] No, not applicable.

Requestor Information

- Approved
Not approved
Pending, need additional information

Classification: [] Medical [] DME [] Lab [] Drugs [] Dental [] Other

Comments: