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 From: To:
- ☐ Price From: To:
- ☐ Other
- ☐ Units From: To:
- ☐ Prior authorization From: To:

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.

- ☐ Approved
- ☐ Not approved
- ☐ Pending, need additional information

Classification: ☐ Medical ☐ DME ☐ Lab ☐ Drugs ☐ Dental ☐ Other

Comments: