



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
OFFICE OF CONTROLLED SUBSTANCES
PRESCRIPTION MONITORING PROGRAM

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

DELAWARE MEDICAID REQUEST FOR PRESCRIPTION REPORT INSTRUCTION SHEET

Who May Receive a Prescription Monitoring Program (PMP) Report

The Office of Controlled Substances may provide PMP reports regarding Medicaid recipients to the Delaware Department of Health and Social Services ([16 Del. C. §4798\(i\)\(2\)e](#)).

Submitting Report Request

- Complete the entire form. All fields are required unless marked "optional."
- Both you and your supervisor must sign the form.
- You may submit the request form either by regular mail or email – your choice. Follow these procedures:

IF you submit by...	THEN...
Mail	Send the completed, signed form to the address above marked to the attention of "PMP."
Email	<p>You must follow these steps to submit by email. Requests that do not conform to these steps cannot be accepted for processing. If you prefer not to follow these steps, please submit your request by mail instead of email.</p> <ol style="list-style-type: none"> 1. Scan the signed form. The scanner will automatically name the file. 2. Save the scanned file to your computer. 3. Rename the scanned file. Use this format for the new name: <ul style="list-style-type: none"> • Requestor's last name followed by a dot • Patient's last name Example: jones.smith 4. Open a new email and address it to delawarepmp@state.de.us. 5. <i>Send your request only by secure, encrypted email.</i>

Regardless how you submit your request, you may opt to have the reports emailed to your email address via secure email or sent by certified mail to your attention. **Requests will be processed within 10-14 business days.**



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MEDICAID STAFF REQUEST FOR PRESCRIPTION REPORT

REQUESTOR – All fields in this section are required.

1. Name: _____ Title: _____
2. Your status (check one):
 DHSS Employee – Enter Employee ID: _____
 DHSS Contractor – Enter Company: _____
3. Your Office Phone: _____ Your Office Email: _____
4. Supervisor's Name: _____ Supervisor's Office Phone: _____

REPORT DETAILS – All fields in this section are required.

5. Date Range for Report: From (month/day/year): _____ To (month/day/year): _____
6. Explain why you need this report: _____

PATIENT (MEDICAID RECIPIENT) INFORMATION – All fields are required unless marked "optional."

7. Medicaid Recipient Full Name: _____
Last/Family First Middle
8. Address (*optional*): _____
City State Zip
9. Date of Birth (month/day/year): _____
10. Client Medicaid Identification Number: _____
11. Does the patient use any other names, addresses, or birthdates (*optional*)? Yes No If yes, list below:

REPORT DELIVERY

12. Indicate how you want the report delivered to you (check one):
 Secure (encrypted) Email – If you are a DHSS employee on the State network, assure that your email account is configured to receive secure email. If you are not on the State network, call Samantha Nettesheim at (302) 744-4518 or email Samantha.nettesheim@state.de.us.
 Mail – The report will be sent to your attention by certified mail, marked confidential. It is your responsibility to assure that it is handled in a secure manner and remains confidential at your location.

All reports will be processed and released to you within 10-14 business days.

DISCLAIMER

By checking the items below and signing this form, I agree and understand:

- HIPAA and all confidentiality and non-disclosure provisions of Delaware Law cover the information contained in the PMP database. All PMP reports are protected health information and not subject to public disclosure under the Freedom of Information Act or any other provision of law.
- Inappropriate access or disclosure of this information is a felony under Delaware Law ([16 Del. C. § 4798](#)) and may result in criminal prosecution.
- Records on this report must be verified before any actions are taken.** A PMP report is an accumulation of data gathered from Delaware-licensed pharmacies and prescribers. The Office of Controlled Substances does not warrant any report to be accurate or complete and expressly disclaims liability for errors and omissions in the contents of this report. For more information about any prescription in a PMP report or to verify a prescription, contact the dispensing practitioner or pharmacy.

Signature of Requestor: _____ Date: _____

Signature of Supervisor: _____ Date: _____

Procedures for submitting this request by mail and email are on the Instruction Sheet.

Requests submitted by email that do not conform to the required steps cannot be accepted for processing.