DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Increased Reimbursement Rates for Behavioral and Mental Health Services

In a coordinated effort with the Division of Substance Abuse and Mental Health (DSAMH), the Division of Medicaid and Medical Assistance (DMMA) increased its reimbursement rates for behavioral and mental health services covered through the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Program; these increases were made effective retroactively back to January 1, 2026.

DMMA worked with its fiscal agent Gainwell Technologies to mass-adjust all affected fee-for-service claims that came through prior to DMMA submitting the rate updates in early February 2026, back to January 1st; this was completed on May 11, 2026.

All prospective claims will process at the increased rates.

In This Edition:

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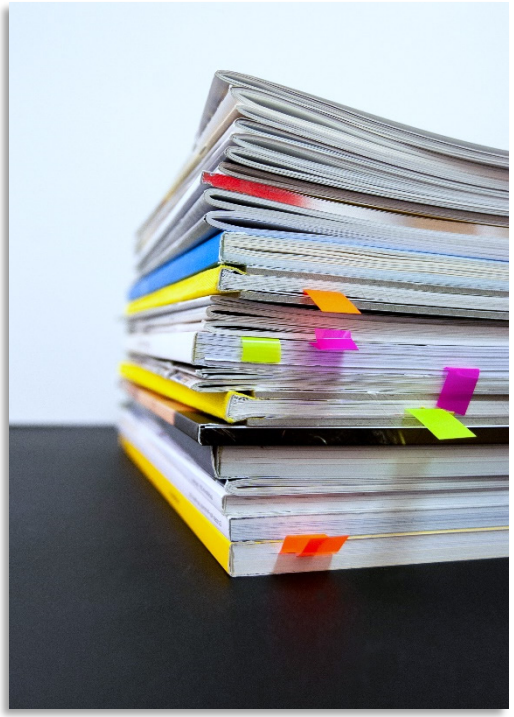
How-To & What's New

Changes to Retroactive Coverage for Assisted Living Medicaid

Effective May 1, 2026, Delaware Medicaid no longer provides retroactive coverage for Assisted Living. Individuals are encouraged to apply for Long Term Care Community Services (LTCCS) promptly, as services will not begin until the individual is deemed eligible (must meet medical and financial criteria) and is enrolled with a Managed Care Organization (MCO).

For more information about provider requirements, service descriptions, and contact information, refer to the Long Term Care Community Services Provider Specific Policy Manual.



New and Updated How-To Documents

- DMES EDI v5010 X12 837 Companion Guide
- How to Download and Import RA into Word
- How to Enrollment Guide for Current In-Network MCO Providers
- How to Enrollment Guide for Fee-For-Service Providers
- How to Enrollment Guide for New MCO Network Providers
- How to Reset an Application Tracking Number
- How to Reset an Application Tracking Number MCO-Only Provider Enrollment
- How to Submit a Dental Claim with TPL on the Portal
- How to Submit a Dental Claim without TPL on the Portal
- How to Utilize Treatment History Panels
- How to View a Member's Eligibility through the Provider Portal

Check It Out!

- 2026 Medicaid & CHIP Beneficiaries at a Glance
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) for Providers

Remittance Advice Reminder

RAs are available on the Provider Portal every **Monday** after 12:00 noon ET.

Helpful Titles

- How-To: Submit a Pharmacy Prior Authorization Request through the Portal
- How-To: Provide a Third-Party Liability Lead through the Portal
- How-To: Convert an MMIS ICN to a DMES ICN & Adjust/Void a Converted MMIS Claim

Delaware Cancer Treatment Program (DCTP)

The Delaware Cancer Treatment Program (DCTP) is available to Delaware residents who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Have no comprehensive health insurance,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Are not eligible for health insurance.

DCTP is also available to Delaware residents with comprehensive health insurance who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Meet maximum out-of-pocket expense for health insurance equal to or more than 15 percent of their household income (does NOT include premiums) *.

***Applicants must submit documentation from their insurance carrier notating the maximum out-of-pocket expense in order to determine eligibility**.

The DCTP application is available online at healthydelaware.org. Please click HERE for more information and to download both the English and Spanish application packet. For more information on DCTP, please call 1-844-245-9580 (TTY 711).

Vaccines for Children (VFC) Program

The Vaccines for Children (VFC) program in Delaware is a federally funded initiative designed to ensure that eligible children receive recommended immunizations at no cost. Administered by the Delaware Division of Public Health, the program provides vaccines purchased by the Centers for Disease Control and Prevention (CDC) to registered healthcare providers throughout the state. These vaccines are available to children who are Medicaid-eligible, uninsured, underinsured, or American Indian/Alaska Native, as defined by the CDC. By removing financial barriers, the VFC program helps protect vulnerable populations from preventable diseases and supports public health efforts to maintain high immunization coverage.

Delaware healthcare providers who participate in the VFC program benefit from reduced out-of-pocket costs and the ability to offer comprehensive immunization services to their pediatric patients. Providers must complete an enrollment process, including a site visit to ensure proper vaccine storage and handling, and are allowed to charge a nominal administrative fee to offset operational expenses. Becoming a VFC provider also enhances the ability to serve children receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, reinforcing the importance of delivering immunizations within the child's medical home.

Interested providers should visit the Vaccines for Children (VFC) Provider website for more details.

Managed Care Organization (MCOs) for 2026

The Delaware Department of Health and Social Services (DHSS) selected three MCOs to operate its Medicaid Managed Care Program.

For more information or to enroll with an MCO, members should login to their DMAP Member Portal or call the Health Benefits Manager at 1-800-996-9969 (TTY 771) (M-Th 8AM – 6PM; F 8AM – 5PM).

For information about provider enrollment, please reach out to the MCOs at the contact numbers below.

AmeriHealth Caritas Delaware	delaware first health	HIGHMARK HEALTH OPTIONS
AmeriHealth Caritas	**Delaware First Health**	**Highmark Health Options**
1-855-707-5818 DentaQuest: 1-800-372-2022	1-877-236-1341 Centene Dental: 1-833-236-1886	1-844-325-6251 United Concordia: 1-800-372-2024

Provider Review / Audits

Medicaid programs are devoting more resources to program integrity, which means providers are more likely to be audited.

All DMAP providers are subject to **routine review and/or audit** by authorized representatives of the DMAP such as, but not limited to, the Surveillance and Utilization Review (SUR) Unit staff, the Medicaid or Independent Professional Review Team, Utilization Review Team, DMAP Fraud Control Unit, or independent audit firms.

Always Be Prepared for an Audit

The most important things providers can do before a review audit are the following:

- Make sure documentation is correct, organized, and accessible.
- Train staff and emphasize the importance of proper documentation.
- Ensure staff are familiar with manuals and regulations.
- Routinely perform self-audits to ensure that staff are maintaining proper documentation.

Review and/or Audit Process

If a provider is chosen for a review and/or audit, they will receive a review audit notification letter in the mail to request that they make certain records available. The notification letter will include a deadline for submitting the records. If it is not possible to submit all the requested records by the deadline specified in the letter, the provider should contact the DMAP SUR Unit staff via phone, email, or letter to request a reasonable extension (see below for contact information).

When the review and/or audit is completed, the provider will receive a "Findings Letter" that explains the Nurse Reviewer's findings. The Findings Letter will identify any alleged errors or deficiencies and will identify the amount of costs questioned and identified in the review and/or audit. Questioned costs represent the dollar value of the claims for services that the Nurse Reviewer determined were not appropriately documented or correctly billed. The Findings Letter will also outline the provider's Redetermination or Appeal Rights for any alleged overpayment identified in the review audit.

Do not ignore the Findings Letter and just think that the review audit will go away. Respond to the letter by the deadline specified in the letter with a payment to satisfy the overpayment or file a Request for Redetermination to provide additional documentation. If a provider files a Request for Redetermination and provides additional documentation, the provider will receive a response via a Redetermination Findings Letter that will explain the SUR Unit's decision regarding the provider's additional supporting documentation.

The last, and perhaps most important, step after a review and/or audit is to **address any issues identified in the Findings Letter**. For example, if documentation deficiencies are identified, the provider could address the concerns by modifying the procedures performed or the documentation used. Similarly, if billing issues are identified, the provider could increase oversight of the billing process to help prevent future errors.

It is important to address the review audit findings. First, addressing the review audit findings increases the likelihood that the finding will not recur if the provider is selected for another review audit in the future. Second, addressing the findings reduces the likelihood of more serious actions, such as suspension or referral to the Attorney General or Office of Inspector General (OIG).

More information: Please refer to Section 1.11, Section 1.12, and Appendix A of the General Policy Manual.

If you have any further questions regarding fraud, waste, or abuse,
please contact the DMMA Surveillance and Utilization Review (SUR) Unit at:
Toll-Free Telephone: 1-800-372-2022 (TTY 711)
Hotline (After-Hours Voicemail Only): 1-800-372-2022, select option 1.
Email: SURreferrals@delaware.gov

Steady as She Goes!

We continue the "soft edit" phase for EVV paid claims where provider partners have been receiving remittance advice messages explaining that non-matching claims will be rejected once the "hard edit" phase begins. In an effort to provide as much time as possible to address any lingering issues, the hard edit date has been extended from March 31, 2026, to **October 1, 2026**. **After this date, claims will be denied without a valid authorization/visit/paid claims match.**

The EVV team is still working diligently with our provider partners to provide as much education and assistance as possible. Providers receiving claim rejection warning(s) should contact their MCO partners, HHAeXchange (formerly Sandata), and/or the State (where appropriate) to avoid any future claims denials. Please stay tuned for any potential updates as they come. Continued thanks to our partners as always for their patience, dedication, and cooperation!

EVV Highlights from Q1:

- 157 unique providers who provide services subject to EVV have registered with HHAeXchange.
- 2,688,830 visits from 130 different providers are reflected in the production environment. Of these, 99% are in a verified/processed status (claims/visits matched).
- Progress continues in engaging with providers and our MCO partners with resolving issues related to EVV, including MCD ID alignment, proper HHAeXchange registration, and other EVV hangups.
- The EVV team has been very successful in helping our provider partners resolve lingering issues with MCD ID registration(s) and other related issues. The team has been conducting provider calls with all MCOs and HHAeXchange representation.
- The EVV team continues to collaborate with our MCO partners, addressing both common and unique concerns/issues and coordinate effective provider outreach.
- The MCOs have also continued to outreach providers who we have identified as 'high-risk' for claims matching issues. We would like to again send many thanks for the continued cooperation!

Provider Reminders:

The EVV requirement is federally mandated. All Personal Care Services (PCS) and Home Health Care Services (HHCS) providers **MUST** register with our EVV vendor HHAeXchange or an alternate EVV vendor of their choosing. To register, please visit the EVV Provider Self-Registration Portal. You **MUST** have your Medicaid Provider Identification Number (MCD ID) to register. If you need help with identifying your MCD ID, please contact DMAP Provider Services from 8:00 AM ET to 4:30 PM ET at 1-800-999-3371 (TTY 711), select option 0, option 4.

Once the registration process is complete, providers may begin accessing the Sandata training resources.

- Providers who are utilizing HHAeXchange/Sandata as their EVV solution: HHAeXchange University
- Providers utilizing an alternate EVV vendor: HHAeXchange University

Provider Forums:

DMAP has hosted several provider forums. Slides from past forums are available on the DMMA EVV webpage. For more information and learn about future forums, visit the DMMA EVV webpage.

Contact Us:

For questions or more information, contact the EVV Provider Service Team at DHSS_DMMA_EVV@delaware.gov.

Updated Dental Fee Schedule

The Dental Fee Schedule is on the DMAP Document Repository.
Effective date is **April 1, 2026**.

Children's Dental Program

Effective **January 1, 2025**, the Division of Medicaid and Medical Assistance (DMMA) has contracted with managed care organizations (MCOs) to provide dental services to children. Listed below is the Dental Benefit Manager (DBM) for each MCO:

AmeriHealth Caritas	Delaware First Health	Highmark Health Options
DentaQuest	Centene Dental	United Concordia
1-800-372-2022 1-877-378-5295	1-833-236-1886	1-800-372-2024

Dental providers wishing to provide dental services to children must enroll in DMAP prior to credentialing with an MCO using the taxonomies below**:**

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Dental Anesthesiologist	1223D0004X	Both
Endodontics	1223E0200X	Both
General Practice	1223G0001X	Both
Oral & Maxillofacial Pathology	1223P0106X	Both
Oral & Maxillofacial Surgery	1223S0112X	Both
Orthodontics and Dentofacial Orthopedics	1223X0400X	Both
Pediatric Dentistry	1223P0221X	Both
Periodontics	1223P0300X	Both
Prosthodontics	1223P0700X	Both

Adult Dental Program

Join us to meet the growing demands of the Adult Dental Program. For additional information regarding the DMMA Adult Dental Program, click HERE. Dental providers wishing to provide adult dental services **must** be enrolled in DMAP and must credential with an MCO.

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Dental Anesthesiologist	1223D0004X	Both
Endodontics	1223E0200X	Individual
Oral & Maxillofacial Surgery	1223S0112X	Individual
Periodontics	1223P0300X	Individual
Prosthodontics	1223P0700X	Individual

ISMP Warns of Mix-Up between Epinephrine Auto-Injector Medication and Trainer Pens

Many epinephrine pen manufacturers package three devices in each carton. Two of the devices contain actual medication, and the third pen is a training pen. The training pen looks similar to the active pen in size, shape, and colors, but it does not contain a needle or medicine. The purpose of the training pen is to allow people and/or caregivers to practice the special method needed to properly administer an epinephrine injection.

Unfortunately, the training pen and active pens are so similar looking that they are easily confused, even though a label on the training pen states, "TRAINER." In addition, upon opening the carton, the blue safety release ends are visible, making the three pens look identical which can cause confusion in an emergency.

The Institute for Safe Medication Practices (ISMP) recommends storing the active EpiPens and their training devices in separate locations. Also, the organization suggests educating caregivers, family members, and babysitters about the difference between the pens.

Read the full article here: https://www.consumermedsafety.org/safety-articles/dont-mistake-an-epipen-training-pen-for-the-real-thing

Be on the Lookout: Cychlorphine in Illicit Drug Supply

Cychlorphine (N-Propionitrile chlorphine) is an emerging high-potency synthetic opioid within the orphine analogue class, increasingly identified in toxicology screens since 2024. Early forensic analyses suggest it exhibits marked μ-opioid receptor agonism, with potency estimated to exceed fentanyl, and activity at κ- and δ-opioid receptors.

Cychlorphine counseling should emphasize that it is an ultra-potent synthetic opioid with a high risk of rapid and severe respiratory depression, even in extremely small amounts. Patients and community partners should understand the importance of recognizing early overdose signs such as slowed or absent breathing, pinpoint pupils, unresponsiveness, or gurgling respirations.

Naloxone use should be reinforced, noting that multiple doses may be required and that having naloxone readily available is essential. Counsel that cychlorphine is frequently found in polysubstance mixtures, especially with stimulants or novel benzodiazepines, which can create unpredictable or mixed toxidromes. Patients should also be aware that standard drug screens may not detect cychlorphine, so any unknown pill or powder should be treated as potentially containing ultra-potent opioids. Harm-reduction strategies like avoiding using alone, starting with very small amounts, using test strips when available, and ensuring naloxone is present can reduce risk but do not eliminate danger. Finally, stress that any suspected exposure or overdose requires immediate emergency medical attention.

Read the United Nations Office on Drugs and Crime (UNODC) alert here: https://www.unodc.org/LSS/Announcement/Details/9403c3d1-12b9-49ac-8604-7da583d38d3b

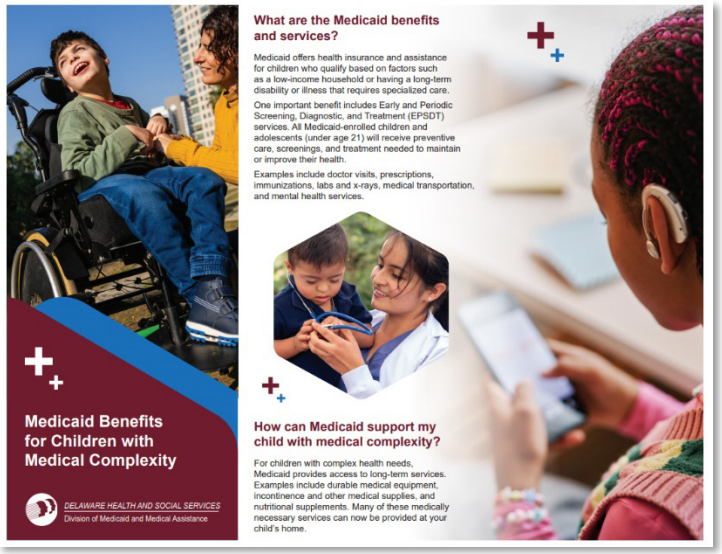
Read the Office of National Drug Control Policy (ONDCP) drug threat notice here: https://ndews.org/wordpress/files/2026/05/ONDCP-Drug-Threat-Notice-Cychlorohine_Final.pdf

Early Periodic Screening, Diagnosis & Treatment (EPSDT) Corner

New Resources for Children with Complex Needs

The Centers for Medicare & Medicaid Services (CMS) recently issued federal guidance to all states in the form of a State Health Official (SHO) Letter # 24-005. This SHO letter, entitled "Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirement," outlined state EPSDT requirements, strategies, and best practices.

In Delaware's continued efforts to promote EPSDT awareness and accessibility and to improve care for children with specialized needs, Delaware's Division of Medicaid and Medical Assistance (DMMA), in collaboration with Delaware's Children with Medical Complexity Advisory Committee (CMCAC) and Children with Medical Complexity Workgroup developed the new resources for families, providers, and other stakeholders involved in the care of children with medical complexities posted to the CMC website.



The new resources available are:

- DE Medicaid Benefits and Services for Children with Medical Complexity Brochure
- DE CMCAC Transitions of Care (TOC) for Children with Medical Complexity Presentation

See all available resources at: https://dhss.delaware.gov/dmma/cmc_resources/

USPSTF Recommendations

Delaware Medicaid provides coverage and reimbursement of all preventative services assigned either grade A or B by the United States Preventive Services Task Force (USPSTF). Click HERE for the comprehensive listing of USPSTF recommendations.

Recommendations with a grade of either A or B

Topic	Description	Grade	Release Date of Current Recommendation
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening: women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum.	B	June 2025
Syphilis Infection During Pregnancy: Screening: asymptomatic pregnant women	The USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity.	A	May 2025
Breastfeeding: Primary Care Behavioral Counseling Interventions: pregnant and postpartum women	The USPSTF recommends providing interventions or referrals, during pregnancy and after birth, to support breastfeeding.	B	April 2025

Opportunities for Public Comment

The U.S. Preventive Services Task Force (USPSTF) provides healthcare providers with an opportunity to influence the future of preventive care through its public comment process. Firsthand clinical experience and expertise are vital in ensuring that recommendations are evidence-based, practical, and applicable to diverse patient populations. The process begins when USPSTF publishes a draft recommendation statement, accompanied by an evidence review. These drafts are made available for a defined public comment period, typically lasting a few weeks. During this time, providers and other stakeholders can submit feedback through the USPSTF website. Comments can address potential gaps, raise implementation concerns, or offer suggestions to enhance the recommendations' relevance and effectiveness.

After the comment period closes, all input is reviewed and carefully considered by the Task Force before finalizing the recommendation. This collaborative process allows healthcare providers to advocate for their patients and contribute to shaping guidelines that impact clinical practice nationwide.

Stay informed about open comment periods through the USPSTF website and take advantage of the opportunity to strengthen preventive care and shape health policy.

Payment Error Rate Measurement (PERM)

PERM Cycle RY25 Updates

The Centers for Medicare & Medicaid Services (CMS) has completed its review of a sample of Delaware's Medicaid and Children's Health Insurance Program (CHIP) payments made during Reporting Year (RY) 2025 (July 1, 2023 – June 30, 2024) as part of the Payment Error Rate Measurement (PERM) program. This review fulfills federal requirements under the Payment Integrity Information Act (PIIA) of 2019.

PERM findings help CMS generate both national and state-specific improper payment rates, and the results help states correct the identified issues and drive program improvements. Claims were reviewed for documentation compliance, medical necessity, and eligibility support. Please be aware that claims identified with errors will be **voided** based on CMS determinations.

Click Here to View the RY 2025 Medicaid & CHIP Supplemental Improper Payment Data Report

CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation is not submitted by providers timely. Consequently, DMMA will recoup the payment from a liable party as a PERM Recovery.

Moving forward, providers should maintain complete and accurate documentation, respond timely to all record requests, and ensure claims fully support all services billed.

The PERM program estimates improper payment rates for Medicaid and CHIP through a three-year cycle. Each state is reviewed once per cycle; Delaware is part of Cycle 1. The review includes:

- Fee-for-Service (FFS) claims
- Managed care capitation payments
- Payments resulting from eligibility determinations

The next PERM reporting year (2028) for Delaware Medicaid and CHIP FFS will review payments made by the state beginning July 1, 2026, through June 30, 2027.

IMPORTANT: Providers must submit proper medical record documentation supporting the paid claim(s) selected for the audit. The required documentation must include sufficient information to validate that provided services were medically necessary and were consistent with the specified diagnosis during the time of the claim payment. If providers have questions about documentation, they should refer to the provider-specific policy manual. Additionally, providers must comply with all federal and state laws, regulations, and billing instructions provided under the Delaware Medicaid program, pursuant to Section 1.6 Provider Contractual/Programmatic Responsibilities in the General Policy Manual, which include:

- 1.6.1 – "A provider who signs a contract with the Delaware Medical Assistance Program (DMAP) is responsible to meet certain conditions in order to remain an eligible provider and receive payment for services rendered."
- 1.6.2 – "Providers are responsible for the accuracy, truthfulness, and completeness of all claims submitted to DMAP. The provider is further responsible for all costs associated with the preparation for the submission of claims, whether prepared or submitted by the provider or by an outside agency or service."
- Refer to Section 1.6 of the General Policy Manual for additional information regarding provider responsibilities.

Questions?

If you have any questions or concerns regarding this program, please contact DeeGee Peterson at DeeGee.Peterson@delaware.gov or Joel Riley at Joel.Riley@delaware.gov.

How To Update Provider Contact Information on the Provider Portal

Enrolled providers can update their contact information (i.e., phone number, mailing address) and demographic information (i.e., accepting new patients, language spoken, etc.) on the DMAP Provider Portal. Accurate contact and demographic information are invaluable to DMAP members in need of medical services.

1. Log into the Secure Portal.
2. Select Characteristics.
3. Select the plus sign (+) next to the address to be updated.
   a. The "Mail To", "Pay To", and "Home Address" can be updated on the Portal.
   b. If the Service Location changes, a new application will be required to enroll the new Service Location.
   c. Contact Information can be updated for a Service Location.
4. Select Edit.
5. Make the necessary updates and select Save.
   a. Ensure the "Mail To" address is up to date to receive DMAP administrative notifications, such as welcome letters, revalidation notifications, and administrative updates.

Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) expanded the groups of individuals who are eligible for retroactive Medicaid coverage. Individuals eligible under the Delaware Healthy Children Program (DHCP) are not eligible for retroactive Medicaid. Click HERE for information about retroactive coverage, eligible members, effective dates, and reimbursement for providers.

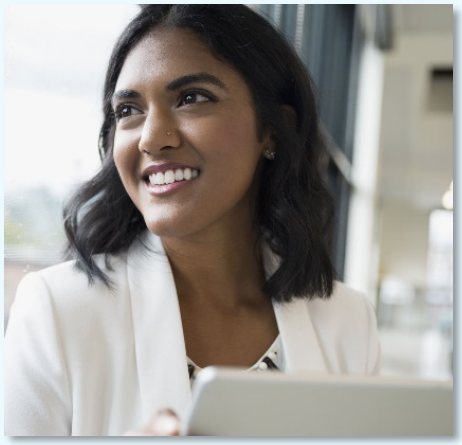
Vaccine for Children (VFC) – Encounter for Immunization

Diagnosis code Z23 (ENCOUNTER FOR IMMUNIZATION) may be used as a primary diagnosis code for immunizations in a physician setting when the member is in the VFC Program.

How-To: Subscribe to Provider Notify Me E-Mail Notifications

For providers who have NOT enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Select the "Notify Me" link in the left panel.
3. Enter and confirm your e-mail address. Choose which types of notifications you want to receive via e-mail.
4. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.



For providers who HAVE enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Log into the Provider Portal using your User ID and Password.
3. After signing in, users with an unverified e-mail address will be directed to the "Subscribe for E-mail Notifications" panel. A confirmation dialog box prompt will appear. Click OK.
4. Verify that the e-mail address on record is correct. If desired, add additional types of notifications.
5. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.

Need Assistance?

Phone & Fax Contacts

Provider Contacts

1-800-999-3371

Provider Pharmacy — **option 0, option 1**
***Fax 302-454-0224**

Provider Services — **option 0, option 2**
(***1 – Member Eligibility; 2 – Claim Status***)
***Fax 302-454-7603**

Provider Enrollment — **option 0, option 4**
***Fax 302-454-7603**

Member Contacts

1-800-996-9969

Health Benefits Manager

Delaware Cancer Treatment Program (DCTP)*
***Fax ONLY 302-454-0223**

Managed Care

Highmark Health Options

Members: 1-844-325-6251
Pharmacies: 1-844-325-6251
Providers: 1-844-325-6251
Dental Benefit Manager:
United Concordia: 1-800-372-2024

AmeriHealth Caritas Delaware

Members DSHP: 1-844-211-0966
Members DSHP Plus: 1-855-777-6617
Pharmacies DSHP: 1-855-251-0966
Pharmacies DSHP Plus: 1-888-987-6396
Providers: 1-855-707-5818
Dental Benefit Manager:
DentaQuest: 1-800-372-2022
or 1-877-378-5295
Prior Authorizations: 1-855-260-9544

Delaware First Health

Members: 1-877-236-1341
Pharmacies: 1-833-236-1887
Dental Benefit Manager:
Centene Dental: 1-833-236-1886
Provider: 1-877-236-1341

Contact Us

Secure Correspondence

Log in to the Provider Portal

Email* Us

delawarepret@gainwelltechnologies.com

**Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.*

Electronic Data Interchange (EDI) Department*

DelawareECSGroup@gainwelltechnologies.com

1-800-999-3371, Option 0, Option 2

Stop Medicaid Fraud Now!

To Submit Anonymously

Call 1-800-372-2022

Or click HERE

Stay Connected!

Sign up for **Notify Me** to receive e-mail notifications about mass adjustments, special program information, program reminders, policy updates, holiday closing, and inclement weather updates.

Click **HERE** to sign up for Provider notifications.

Click **HERE** to sign up for Member notifications.

NOTE: If you are a Registered Provider/Delegate/Trading Partner, log into the Portal to update your Notify Me Subscription.