Wellpoint
District of Columbia

Condition Care Program Referral Form

Wellpoint District of Columbia, Inc. | Medicaid

Thank you for referring your patient(s) to our Condition Care (CNDC) program. All information contained on this form is strictly confidential and may become part of your patient's record.

Referring physician information		
Referring physician's name:		
Referring physician's phone:	Referring physician's email:	
Member information		
Member name:		
Member ID:	Member DOB:	Referral date:
Member phone:	Member email:	
Health condition (See CNDC eligible conditions*.):	Reason for referral:	
Any additional details:		
Member information		
Member name:		
Member ID:	Member DOB:	Referral date:
Member phone:	Member email:	
Health condition (See CNDC eligible conditions.):	Reason for referral:	
Any additional details:		
Member information		
Member name:		
Member ID:	Member DOB:	Referral date:
Member phone:	Member email:	
Health condition (See CNDC eligible conditions.):	Reason for referral:	
Any additional details:		

*CNDC eligible conditions link: https://www.wellpoint.com/dc/provider/state-federal/patient-care/health-education/condition-care

Please email this form to Condition-Care-Provider-Referrals@wellpoint.com. For more information about the Condition Care Program, visit our website at provider.wellpoint.com/dc.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.