Condition Care Program Referral Form

Iowa | Iowa Health Link • Hawki

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

Referring physician information	
Referring physician name:	
Referring physician phone:	Referring physician email:

Member information		
Member name:		
Member ID:	Member DOB:	Referral date:
Member phone:	Member email:	
Health condition (see condition care [CNDC] eligible conditions):	Reason for referral:	
Any additional details:		

Member information		
Member name:		
Member ID:	Member DOB:	Referral date:

Member information	
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:		

Please email this form to Condition-Care-Provider-Referrals@wellpoint.com by secure email. For more information about the Condition Care Program, visit our **https://provider.wellpoint.com/ia**.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled in 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.