

## Condition Care Program Referral Form

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

[provider.wellpoint.com/tn/](https://provider.wellpoint.com/tn/)

Medicaid services provided by Wellpoint Tennessee, Inc.

We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call **833-731-2154**.

Information about the civil rights laws can be found at [tn.gov/tenncare/members-applicants/civil-rights-compliance.html](https://tn.gov/tenncare/members-applicants/civil-rights-compliance.html)

<b>Member information</b>		
Member name:		
Member ID:	Member DOB:	Referral date:
Member phone:	Member email:	
Health condition ( <b>See condition care [CNDC] eligible conditions</b> ):	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 website **here**.