BlueCross BlueShield of North Carolina | HealthyBlue

Condition Care Program Referral Form

Thank you for referring your patient(s) to our 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 **condition care [CNDC] eligible conditions**):	Reason for referral:	
Any additional details:		
Member's information		
Member's name:		
Member's ID:	Member's DOB:	Referral date:
Member's phone:	Member's email:	
Health condition (See **CNDC eligible conditions**):	Reason for referral:	
Any additional details:		
Member's information		
Member's name:		
Member's ID:	Member's DOB:	Referral date:
Member's phone:	Member's email:	
Health condition (See **CNDC eligible conditions**):	Reason for referral:	
Any additional details:		

Please email this form to **Condition-Care-Provider-Referrals@healthybluenc.com** by secure email. For more information about the Condition Care Program, visit our website **here**.

https://provider.healthybluenc.com

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