Medicaid Managed Care

Condition Care Program Referral Form

This communication applies to the Medicaid programs for Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA).

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 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 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:	

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Any additional details:

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