



Interpreter Services Request Form

At Alameda Alliance for Health (Alliance), we provide no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm your patient's eligibility before requesting services. Please complete this form to request interpreter services.

INSTRUCTIONS

1. Please print clearly, or type in the fields below, and return by fax to **1.855.891.9167**.
2. Submit the forms by fax at least **five (5) business days** (Monday-Friday, excluding holidays) prior to the appointment date. For ASL, **five (5) business days** is recommended, but not required.
3. If you need to **revise a request**, please cancel the original request and submit a new one.

For questions or cancellations, please call the Alliance Provider Services Department at **1.510.747.4510**.

SECTION 1: PATIENT INFORMATION	
Last Name: _____	First Name: _____
Alliance Member ID #: _____	Date of Birth (MM/DD/YYYY): _____
Home Phone Number: _____	Cell Phone Number: _____

SECTION 2: INTERPRETER SERVICE TYPE (CHECK ONLY ONE TYPE OF SERVICE)	
<input type="checkbox"/> Telephone Interpreting by Appointment	<input type="checkbox"/> In-Person Interpreting
<input type="checkbox"/> Video Interpreting by Appointment (<i>if available at clinic location</i>)	
Language: _____	Special Requests (optional): _____

SECTION 3: APPOINTMENT DETAILS	
<i>For in-person appointments, please include address information.</i>	
<i>For prescheduled video or telephonic appointments, please provide call-in information and/or link.</i>	
Date (MM/DD/YYYY): _____	Start Time: _____ Duration: _____
Provider Name: _____	Clinic Name: _____
Address (include floor/suite): _____	
Department/Specialty: _____	City: _____ Zip Code: _____
Call-In Number/Code: _____	
Platform Link/Meeting ID/Password: _____	
Please complete if requesting an in-person interpreter:	
Why is an in-person interpreter required?	
<input type="checkbox"/> Complex course of therapy or procedure including life-threatening diagnosis (<i>examples: cancer, pre-surgery instructions, and evaluation or reevaluation for physical and occupational therapy</i>)	
<input type="checkbox"/> Highly sensitive issues (<i>examples: sexual assault, abuse, end-of-life, and initial evaluation for behavioral health</i>)	
<input type="checkbox"/> Other condition (<i>please include justification</i>): _____	

SECTION 4: REQUESTOR INFORMATION	
Name: _____	Email: _____
Phone Number: _____	Fax: _____ Date: _____

Telephonic interpreter services are available for Alliance members at any time, 24 hours a day, 7 days a week without an appointment at **1.510.809.3986**.

To view and download this form, please visit www.alamedaalliance.org/provider-forms.