Interpreter Services Request Form

Please use this form to request interpreter services for Alameda Alliance for Health (Alliance) members. You can also use this form to request prescheduled in-person American Sign Language (ASL) and rare languages for complex or high-risk, highly sensitive, or specialized needs that meet Alliance guidelines. The Alliance provides interpreter services at no cost for all covered services and serves as a supplemental resource to ensure contracted providers can meet the language access needs of Alliance members.

Instructions

1. Please print clearly or type in all the fields below, as appropriate.
2. Submit the completed form to the Alliance Cultural and Linguistic Services (CLS) Department via fax at **1.855.891.9167** or on the Alliance Provider Portal.

The provider is responsible for verifying the members' eligibility on the date of service. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click the Provider Portal button in the top-right corner of our home page. You will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond. If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**.

Please note: Telephonic interpreter services (available 24/7): **1.510.809.3986**. To view and download this form, please visit **www.alamedaalliance.org/provider-forms**.

Section 1: Member Information

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Alliance Member ID Number: _____

Home Phone Number: _____ Cell Number: _____

Section 2: Requestor Information

Last Name: _____ First Name: _____

Phone Number: _____ Fax Number: _____

Email: _____

Section 3: Interpreter Service Type

Please select only one (1):

☐ Telephone (by appointment) ☐ Video (by appointment) ☐ In-person

Language: _____

Special Requests: _____

Section 4: Appointment Details

In-Person: Include full address
Video/telephone: Provide call-in information and/or URL)

Date (MM/DD/YYYY): _____ Start Time: _____

Duration: _____

Provider Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Call-In Information/URL: _____

Section 5: Prescheduled Interpreter Service Criteria

Please select only one (1):

☐ Complex physical therapy evaluation/ re-evaluation

☐ Complex pre-operative/pre-procedure instructions (e.g., cancer or open-heart surgery)

☐ End-of-life care

☐ Infusion (e.g., chemotherapy)

☐ Initial behavioral health evaluation

☐ Rare language

☐ Sexual assault or abuse

☐ Transplant consultation

☐ Other (specify): _____

If Other is selected:

Briefly explain why internal resources are not sufficient and why an in-person interpreter is needed.

If Other is selected, please include the provider signature:

Signature: _____ Date: _____