ALAMEDA Alliance FOR HEALTH

Interpreter Services Appointment Request Form

INSTRUCTIONS:

1. Please print clearly.
2. Fields with a (*) must be completed.
3. Forms must be submitted by fax at least **five (5) working days** prior to the date of the appointment.
4. Please return form by fax to Alameda Alliance for Health (Alliance)
   Fax Number: **855.891.7172**

For questions, please call the Alliance Provider Services Department at **510.747.4510**.

PATIENT INFORMATION		
*MEMBER NAME		*MEMBER DOB _____ / _____ / _____
*MEMBER ID NUMBER		MEMBER CONTACT PHONE NUMBER
INTERPRETER SERVICE TYPE (PLEASE CHECK ONLY ONE)		
☐ TELEPHONE INTERPRETING *(scheduling is optional)* ☐ VIDEO INTERPRETING *(if available at clinic location)* ☐ IN-PERSON INTERPRETING		*LANGUAGE PREFERENCES ☐ FEMALE ☐ MALE
APPOINTMENT DETAILS		
*APPOINTMENT DATE _____ / _____ / _____	*APPOINTMENT START TIME	*APPOINTMENT DURATION
PROVIDER/FACILITY NAME		PROVIDER SPECIALTY
PROVIDER ADDRESS (INCLUDE DEPARTMENT/FLOOR/SUITE)		
PLEASE DESCRIBE THE NATURE OF THE VISIT (CHEMO, RADIOLOGY, ETC.) AND JUSTIFICATION FOR INTERPRETER SERVICE TYPE.		
*NAME OF PERSON REQUESTING INTERPRETER		*PHONE NUMBER
*DATE SUBMITTED _____ / _____ / _____		

Telephonic Interpreter Services are available 24/7 without an appointment by calling **510.809.3986**.

HED Revised 12/18
C&O Revised 12/18