

Medicaid Sign Language Interpreter Request Form

Questions about this contract: SignLanguageInterpreters@dshs.wa.gov or call 360-439-4559

Questions about filling out the form: INTERPRETERSVCS@hca.wa.gov

TO BE COMPLETED BY THE PURCHASER. *Purchaser is ultimately responsible for payment		
1. Purchaser (Person/facility requesting Interpreter for appointment).	2. Telephone Number (with area code):	3. Date of Request:
Billing information: If Medicaid does not cover this appointment, the purchaser is responsible for payment. Under ADA, the medical provider is legally responsible to provide access. The agency will fill request and if Medicaid denies claim, the purchaser accepts responsibility to pay services by submitting this request form.		
4. Medical Service Provider's Name:	9. NPI Number:	
5. Contact Phone Number:	10. Appointment Type (select one)	
6. Contact Fax Number:	A) <input type="checkbox"/> Physical Health Specialty:	B) <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Mental Health (MH) <input type="checkbox"/> Substance Use Disorder (SUD)
7. Contact Email:		
8. How do you want the Interpreter confirmation? Select all <input type="checkbox"/> or pick one: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> email		
11. Name of Medical Building (if applicable):	13. Parking and other information:	
12. (a) Appointment Address: (b) City (c) State: WASH (d) Zip Code (e) Floor: (f) Room Number:		
**Virtual Meeting/Platform:		
14. Patient's Name	15. Appointment Date	16. A) Scheduled Start Time <input type="checkbox"/> am <input type="checkbox"/> pm B) Scheduled End time <input type="checkbox"/> am <input type="checkbox"/> pm
17. Patient's DOB	18. Patient's Gender	19. Patient's Provider One Number:
20. Patient is Deaf <input type="checkbox"/> Deaf <input type="checkbox"/> DeafBlind (Low Vision) or <input type="checkbox"/> DeafBlind (Tactile) <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Oral <input type="checkbox"/> Other		
21. Specific Interpreter/agency Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Add Name of Interpreter/agency:		22. Specific gender of Interpreter Requested? If yes <input type="checkbox"/> Male <input type="checkbox"/> Female
23. Name(s) of preferred Interpreters *Attach Client Choice Form if you have one.		
TO BE COMPLETED BY HEALTH CARE AUTHORITY (HCA): 1. HCA Provider One Reference Number:		
TO BE COMPLETED BY THE CONTRACTOR (Referral Agency or Independent Interpreter)		
1A. Interpreter's Name:		1B. Additional Interpreter if more than 90 minutes or team required:
2. Additional commute time requested? <input type="checkbox"/> Yes <input type="checkbox"/> No		3. Justification:
TO BE COMPLETED BY THE INTERPRETER		
1. Address of origin: *closest Intersection acceptable with city/zip code:		Zip Code
2. Start Time: End Time:	3. Total Hours worked:	4. Mileage to appointment: <input type="checkbox"/> One Way or <input type="checkbox"/> Round Trip. You should not include mileages to your next assignment.
5. Other fees/Total:	6. Receipt included: <input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:
TO BE COMPLETED AT APPOINTMENT		
SERVICE: Was this service completed? <input type="checkbox"/> Yes, complete VERIFICATION section below <input type="checkbox"/> No, check the correct reason why this service was not completed:		
NO SHOW BY: <input type="checkbox"/> Patient <input type="checkbox"/> Service Provider <input type="checkbox"/> Interpreter <input type="checkbox"/> Other:	CANCELLATION BY: <input type="checkbox"/> Patient <input type="checkbox"/> Medical Service Provider <input type="checkbox"/> Other:	CANCELLATION INFORMATION (REQUIRED) Date: Time: <input type="checkbox"/> am <input type="checkbox"/> pm Name of person cancelling: *Only cancellation less than 48 hours are billable*
VERIFICATION* You must have HCA Provider One reference number in order to bill HCA*		
Interpreter's Signature: _____		
DO NOT SIGN unless section above are completed. Be sure to check for accuracy and Interpreter's signature above. Interpreter signature not required if cancelled. Use Comment section below if needed.		
Signature of Service Provider/Employee/Coordinator		Date
Printed Name		Title/Position
COMMENTS:		

Medicaid Sign Language Interpreter Request Form

Questions about this contract: SignLanguageInterpreters@dshs.wa.gov or call 360-439-4559

Questions about filling out the form: INTERPRETERSVC@hca.wa.gov

Fill out this Request Form and send it to Health Care Authority.**

INSTRUCTIONS: Fill in complete information for the following:

1. Name of the person/facility filling out the form, and who is financially responsible for payment of the services. Put down your name with "on behalf of..." if you are filling it out for someone else.
2. Phone number or email address to reach you or a representative for you to request additional information to this request.
3. Date of Request Form being completed and submitted.
4. Name of the medical provider that the Interpreter will be working with.
5. Phone number for medical provider.
6. Fax number for medical provider.
7. Email for medical provider.
8. How do you want to be notified of your assigned interpreter? By phone, fax or email? Select all or check one.
9. The medical provider's NPI Number
10. Indicate the type of appointment. Is this Physical Health or Behavioral Health? If physical, indicate specialty if applicable. If behavioral, select mental health or substance use disorder.
11. Name of medical Building if any
12. Address of appointment including b) city, c) Zip Code, d) floor and e) room number
13. Parking information and other essential information if needed or helpful. Please consider security, if badge required etc. Such as location for free parking, parking garages, time restriction etc.
14. Patient's name.
15. Appointment date.
16. Appointment scheduled start time and Appointment scheduled end time. The interpreters will be paid if the appointment goes past their scheduled end time.
17. Patient's date of birth.
18. Patient's gender.
19. Patient's Provider One number.
20. Patient's hearing status for communication needs. If you are not sure, ASK the patient. This helps the agency assign an appropriate Interpreter.
21. Specific Interpreter or Agency requested? Name of Interpreter/Agency (drop down list of contractors).
22. Specific gender of the Interpreter requested?
23. Name of the preferred Interpreter(s) if any. Attach the client choice form if the client gives you one.

To Be filled out by HCA:

1. Health Care Authority (HCA) requires a Provider One reference number in order to authorize services. You must have this number on the form.

To be completed by the Contractor (Referral Agency or Independent Interpreter)

1. **A.** This is the name of the assigned Interpreter. Please be mindful that if the patient requests the name of the Interpreter, you should give it to them.
B. An additional Interpreter is required if Appointment is longer than 90 minutes, and a Deaf Interpreter (CDI or QDI) is conditional for some Appointments. The Contractor will advise you regarding the patient's communication needs.
2. Additional commute time requested (yes or no). 3. Justification (Explain why a local Interpreter is not assigned).
* Each Interpreter must have their own form.

To be completed by the Interpreter:

1. Interpreter's address. We do not require an exact address. You can use the closest intersection with city or zip code.
2. Appointment actual start time, even if it is different than the requested time.
3. Appointment actual end time, even if it is different than the requested time.
4. Mileage to appointment.
 - a. Include the mileage to the appointment and indicate if this is a round trip. If the Interpreter travels to another assignment, round trip miles are not permitted.
 - b. Additional paid time may be requested by the Interpreter if the commute is more than 1 hour. You request the appointment time and additional time from HCA.
5. Total time worked. This does not include the commute agreement.
6. Any travel related expense such as tolls or parking. Include receipt for reimbursement.

To Be Completed at Appointment by Provider/Employee/Coordinator: Each Interpreter must have their own form to sign.

Was service completed? If yes, complete verification section. Indicate if Interpreter arrived on time. Interpreter adds signature. If no, check box for reason why. In both cases, have provider add signature, date, printed name and title/position.