\*If you are using this form, you are a medical provider requesting sign language interpreter services through Health Care Authority’s reimbursement program. This form must be submitted through Provider One. If you have questions about the process, please contact HCA at: INTERPRETERSVCS@hca.wa.gov

1. **TO BE COMPLETED BY THE PURCHASER**
2. Purchaser (Person/facility requesting Interpreter for appointment):
3. Telephone Number (with area code):
4. Date of Request:
5. Medical Provider’s Name:
6. Billing Address:
7. NPI Number:
8. Appointment Type: Choose an item.

\*If Physical Health, Specialty:

\*If Behavioral Health: Choose an item.

1. Optional Fax Number:
2. Optional Email:
3. Name of Medical Building (if applicable):
4. Appointment Address:
5. City:
6. State: Washington and Zip Code:
7. Floor and Room Number:
8. Optional Parking and other information:

\***Telehealth Appointment Information**

1. Is this a Virtual Meeting (i.e., Telehealth)? Choose an item.
2. Platform (required): Choose an item.
3. **PATIENT INFORMATION**
4. Patient’s Name:
5. Patient’s DOB:
6. Patient’s Provider One Number:
7. Patient’s Gender:
8. Appointment Date:
9. Scheduled Start Time:
10. Scheduled End time:
11. Patient’s Hearing Status: Choose an item.
12. **Sign Language Interpreter Information**
13. Specific Interpreter/Agency Requested?
14. Specific gender of Interpreter Requested?
15. Name(s) of preferred Interpreters:       \*Attach Client Choice Form if you have one.
16. **TO BE COMPLETED BY HEALTH CARE AUTHORITY (HCA)**
17. HCA Provider One Reference Number:
18. **TO BE COMPLETED BY THE CONTRACTOR**
19. Interpreter’s Name:
20. Additional Interpreter if more than 90 minutes or team required:
21. Additional commute time requested?
22. Justification:
23. **TO BE COMPLETED BY THE SIGN LANGUAGE INTERPRETER**
24. Address of origin: \*closest Intersection acceptable with city/zip code:
25. Actual Start Time:
26. End Time:
27. Total Hours worked:
28. Mileage to appointment:       One Way or Round Trip.

\*You should not include mileages to your next assignment.

1. Other fees/Total:
2. Receipt included? Choose an item.

**V. Service Verification to be completed and signed after the appointment**

1. Was this service completed? Choose an item.
2. If No, check the correct reason why this service was not completed: Choose an item.

**CANCELLATION INFORMATION (REQUIRED)**

1. Appointment cancelled by: Choose an item.
2. Date Appointment was cancelled:
3. Time Cancelled:
4. Name of person cancelling:

\*Interpreters cancelled before 48 hours are not billable.

Interpreter’s Signature and Date:

DO NOT SIGN unless sections above are completed. Be sure to check for accuracy and the Interpreter’s Signature above. Interpreter signatures are not required if cancelled. Use the comment section below as needed.

Signature of person from meeting and date:

Printed Name:      Tile/Position:

Notes: