**DISCLAIMER: Ultimately the provider is responsible to hire and pay for Sign Language Interpreter Services. Providers may qualify to use Health Care Authority’s Medicaid Program. Providers must have access to Provider One. For more information email** [**INTERPRETERSVCS@hca.wa.gov**](mailto:INTERPRETERSVCS@hca.wa.gov)

1. Enter to name of the person filling out this form.
2. Enter your phone number in case the agency has follow up questions.
3. Enter the date you are filling out this request.
4. Name of the Medical Provider who will be using the Interpreter.
5. \*Billing address (even though payment is through health care authority, you still need to provide billing information.
6. NPI number for provider.
7. Identify the appointment type: If physical health, add specialty. If Behavioral Health, indicate if Mental Health of Substance Abuse Disorder.
8. Optional Fax Number.
9. Optional Email address.
10. Name of the medical building so Interpreters can find the site.
11. Appointment address.
12. Add city.
13. And Zip Code.
14. Floor and room number.
15. Optional parking information and any other essential details.

Is this is virtual Meeting? If yes, add the Platform.

**Patient Information:**

1. Patients name.
2. Patient’s DOB.
3. Patient’s Provider One number.
4. Patient’s Gender.
5. Patient’s Appointment Date.
6. Start time (please consider adding a few minutes before for check-in)
7. End time.
8. Patient’s Hearing Status: select from drop down list.

The provider portion of the form is finished. Be sure to upload into Provider One.

**Sign Language Interpreter Information:**

1. Did the patient request a specific interpreter or agency? If so, please indicate.
2. Did the patient ask for a specific gender?
3. Did the patient give you the names of their preferred interpreters? A preferred Interpreter is an interpreter in which the patient has identified as someone who can provide effective communication. Not all Interpreters have the same skill set.

**\*The provider portion of this form is finished. Be sure to upload this form into Provider One.\***

**To be filled out by Health Care Authority (HCA):**

1. Health Care Authority will add a Provider One reference number that ensures the client is eligible and HCA will cover the cost of the Interpreter(s) this appointment.

**To be filled out by the Contractor:**

1. The contractor will provide the Interpreter’s name
2. An additional interpreter if required
3. Information about commute time
4. Add justifications

**To be filled out by the Sign Language Interpreter:**

1. The intersection, city and zip code at the start of the commute.
2. The actual start time
3. The actual end time
4. Total hours worked
5. Total mileages to appointment one way.
6. Other fees such as parking.
7. Indicate if a receipt is attached.

**Service verification information to be filled out by someone on site and by the Interpreter after the** **appointment.**

1. Indicate if services were completed.
2. If not, select reason why.

Add cancellation information

1. Date and time appointment was cancelled and by whom

**\*The Interpreter’s Signatures and a signature from someone on the site is required for payment\***