ITASCA INTERPRETATION SERVICES

*APPOINTMENT ID#*_____

Itasca Staff Only:
REJECTED: No Billable Insur. _____ Unable to Verify _____
Too Old_____ Not Enough Info _____ No Signature _____

☐ UCARE ☐ HEALTHPARTNERS ☐ MA ☐ BLUEPLUS ☐ OTHERS _____

Appointment Date:_____/_____/_____ **Appointment Time:**_____ AM / PM

Patient / Client Information

[Name] _____

[Address] _____

[City / State / Zip] _____

[Phone Number] _____

[Insurance ID Number / MRN] _____

[Date of Birth / Gender] _____

[Interpreter Performance] ☐ Satisfied ☐ Not Satisfied

Facility Information

[Name] _____

[Address] _____

[City / State / Zip] _____

[Phone Number] _____

[Practitioner Name] _____

[Type of Service] _____

[Responsible Party]

WOF must be submitted within 30 days from date of service without penalty.

Interpreter Information

Name: _____
First Middle Last Language

Interpreter Signature | MN Roster ID# | Date

To be Completed by Clinic/Support Staff ONLY

TYPE OF SERVICE (CIRCLE): CLINICAL HOME OTHER _____

☐ Pharmacy visit ☐ No Show/Cancel ☐ Satisfied

☐ Patient present Staff initial _____ ☐ Conference Call ☐ Not Satisfied (Comment section below)

Arrival Time: _____ AM / PM **Start Time:** _____ **End Time:** _____ AM / PM

By signing this form you are hereby authorizing Itasca to provide this service and the above form is complete and correct.

_____ Clinic Staff Signature | _____ Date | _____ Printed Name

Comments: _____

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