ITASCA INTERPRETATION SERVICES

*APPOINTMENT ID#*_____

Itasca Staff Only:
REJECTED: No Insurance ___ Unable to verify___
Too old ___ Not enough info ___ No Signature ___

☐ UCARE ☐ HEALTHPARTNERS ☐ MA ☐ BLUEPLUS ☐ OTHERS

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

Patient 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] _____

[Dept or Procedure] _____

[Responsible Party]

Interpreter Information

Name: _____
First Middle Last Language

Interpreter Signature	MN Roster ID#	Date

To be Completed by Clinic/Support Staff ONLY Type of Service: ☐ Clinical ☐ Home Visit ☐ Other

☐ Pharmacy visit ☐ No Show/Cancel ☐ Satisfied

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

Arrival Time: _____ AM / PM **Departure 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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