**INTERPRETER REQUEST FORM**

*Instructions: Please complete this form at least three days**prior to the appointment date and send it to* [*RMAlanguageservices@uscridc.org*](mailto:RMAlanguageservices@uscridc.org)*. Completing this form does not mean interpreter service will be provided. If eligible, you will receive an email stating that your client has been approved for the service and an interpreter will call the healthcare provider at the time of the appointment.*

|  |  |
| --- | --- |
| **Client Information:** |  |
| First and Last Name: | Click or tap here to enter text. |
| A Number: | Click or tap here to enter text. |
| RMA Identification Number  *(Health Benefit Card Number)* | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Email Address: | Click or tap here to enter text. |
| **Case Manager’s Information:** |  |
| Case Manager’s Name: | Click or tap here to enter text. |
| Name of Agency: | Click or tap here to enter text. |
| Case Manager’s Phone Number: | Click or tap here to enter text. |
| Case Manager’s Email: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Provider Information:** |  |
| Provider’s Name: | Click or tap here to enter text. |
| Provider’s Address: | Click or tap here to enter text. |
| Provider’s Phone Number: | Click or tap here to enter text. |
| Provider’s Email: | Click or tap here to enter text. |
| **Appointment Information:** |  |
| Date of Appointment: | Click or tap to enter a date. |
| Time of Appointment: | Click or tap here to enter text. |
| Total Hours Needed: | Click or tap here to enter text. |
| Language Needed: | Click or tap here to enter text. |
| Gender Preferred  *(For in-person interpretation only)* | Choose an item. |