




MEDICAID Interpreter Services Fax Request Form

for RItE Care, Rhody Health Partners and Rhody Health Partners ACA only.

Language Services requests require 72 business hours' notice prior to the appointment.
 American Sign Language (ASL) requests require 14 business days' notice prior to appointment.

	Member ID # _____	Fax this form to 401-459-6021 NHPRI
	Member ID # _____	Fax this form to 857-304-6400 THP
	Member ID # _____ MUST INCLUDE GROUP #	Fax this form to 888-624-2748 UHC

TO BE COMPLETED BY PROVIDER REQUESTING SERVICE FOR ROUTINE APPOINTMENTS

Requestor Information:

Provider's Full Name: _____ Today's date: _____
 Phone #, Extension: _____
 Provider's Address: _____
 Individual Completing Form: _____
 Type of Appointment: Medical Dental Behavioral Health
 (This form is for one member for one medical, dental or behavioral health appointment.)

Service Information: (Member name, Date, Location and Type of Interpreter Needed)

Member Name: _____ D.O.B. _____
 Member's Phone #: _____
 Date of Visit/Service: ____/____/____ Time: ____ am ____ pm
 Address: _____
 Special Instructions (apartment #, floor, parking, etc.): _____

Location: (COMPLETE ADDRESS where interpreter services are to be provided: office number, name of clinic, dept name and floor # or other)

 Language Needed: _____ **OR** Sign Language Interpreter: _____
 (Preferable): _____ Male _____ Female _____ No Preference
 Special Instructions (apartment #, floor, parking, etc.): _____

If you need to cancel a request, fax request form to: 1-888-624-2748 UHC or 1-401-459-6021 NHPRI or 1-857-304-6400 THP

Internal Use Only:

Member Eligible? Y/N Date Validated _____ Validated By: _____
 Date Faxed to Horton/Powell _____ Faxed by: _____ Appointment Number _____