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.

Neighborhood Health Plan OF RHODE ISLAND™	Member ID #_____	Fax this form to 401-459-6021 NHPRI
TUFTS Health Plan	Member ID #_____	Fax this form to 857-304-6400 THP
United Healthcare Community Plan	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: Today's date: _____

Provider's Full Name: _____ 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_____