



People For People – Interpreter Services Broker

Medical Facility Request Form

PHONE: (800) 233-1624 FAX: (509) 853-2151

(Fax must be received 3 business days in advance before 4:00PM)

USE THIS FORM FOR 1 TIME REQUESTS ONLY

Date Request is Submitted to Broker: _____ **Time:** _____

| | | |
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| Section 1 | Client Full Name: _____ <small>(Last name, First name, MI)</small> | Client Information |
| | Client ID #: _____ DOB: _____ | |
| | Client Telephone Number: _____ | |
| | Client Gender: Check appropriate box Male <input type="checkbox"/> Female <input type="checkbox"/> | |

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|---|---|-----------------------------|-------------------------|-----------------------------|-----------------------------|-------|
| Section 2 | Appointment Address: _____ | Appointment Information | | | | |
| | City: _____ Zip Code _____ | | | | | |
| | Facility Name: _____ | | | | | |
| | Provider's Name: _____ Phone #: _____ | | | | | |
| | Medical Reason for Appointment: _____ | | | | | |
| | Is this service being billed to Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| | Language Requesting: _____ | | | | | |
| | <table border="0"><tr><td>Appointment Date</td><td>_____</td><td>Scheduled Start Time</td><td>_____</td><td>Anticipated End Time</td><td>_____</td></tr></table> | | Appointment Date | _____ | Scheduled Start Time | _____ |
| Appointment Date | _____ | Scheduled Start Time | _____ | Anticipated End Time | _____ | |
| Does the client know that an interpreter has been requested for this appointment? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| Special Instructions/Accommodations: _____ | | | | | | |

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| Section 3 | Requesting Facility: _____ | Requestor Information |
| | Requester's Name: _____ Title: _____ <small>(Last Name, First Name, MI)</small> | |
| | Requestor's Fax Number: _____ Phone #: _____ <small>Fax machine <i>must be available</i> 24 hours for confirmations</small> | |

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| Section 4 | <i>The facility named in Section 2 (if not the requesting facility) must review the following information for accuracy and confirm by initialing all fields below.</i> | Referral Validation |
| | Client Information: _____ Appointment Date & Time: _____ Facility Address: _____ _____ Person Verifying the Information (Print) _____ Title _____ | |

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| Section 5 | Vendor Assigned: _____ Authorization Code: _____ | PFP Use Only |
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