

DEAF COMMUNITY SERVICES OF SAN DIEGO, INC.
3930 Fourth Avenue, Suite 300, San Diego, CA 92103
(Voice) 619-398-2488(TTY) 619-398-2440 (Fax) 619-398-2490
scheduler@dcsofsd.org or interpreting@dcsofsd.org
WWW.dcssofsd.org

SIGN LANGUAGE INTERPRETER REQUEST FORM

Today's Date: _____

Start: _____ *am/pm*

Service Date: _____

Medical Check In Time: _____

Day of the week: _____

End: _____ *am/pm*

Name of Deaf Person(s): _____

Name Organization: _____

Name of person requesting service: _____ **Phone Number:** _____

Appointment Location: _____

Site Phone Number: _____ **Site Contact Person:** _____

Site Fax Number: _____ **e-mail address:** _____

Nature of Appointment: _____

Medical Record #: _____ **Case/Code#:** _____ **PO #:** _____ **Other:** _____

Preferred Interpreter(s) if any: _____ *male / female*

MAIL INVOICES TO THE ADDRESS BELOW. TO PAY BY CREDIT CARD SIGNATURE IS REQUIRED.

Company Name: Molina Healthcare Attention: Health Education

Address: 200 Oceangate, Suite 100 City Long Beach State CA Zip 90802

Phone: 562-435-3666 ext. 127421 Fax: 562-499-6187 e-mail : _____

Credit Card #: _____ EXP ____/____ CRV _____ Signature: _____

DCS Only below this point

Notes:

