



Request taken by:

Date:

Time:

Office use only

Interpreter Service Request

Date Needed:

Start Time: am/pm

End Time: am/pm

Name of Requestor:

Phone #:

Agency Name: Molina Healthcare

Fax #:

ASSIGNMENT INFORMATION

Deaf Consumer:

MR/SS#:
(for correct billing)

Facility:

Assignment Address:
(street) (dept/floor/suite)

City & Zip:

Cross Street:

Parking location:

Nature of Assignment:

Doctor/Counselor Name:

Special Instructions:

On-Site Contact Person:

DIRECT Phone/cell#:
(or pager/sidekick address)

BILLING INFORMATION

Bill To: Molina Healthcare, Inc., 200 Oceangate, Suite 100

City, State, Zip: Long Beach, CA 90802

Attention To: Health Education

PO# (if applicable): _____

Authorized By

Title

Phone #

Today's Date

ALL CANCELLATIONS MUST BE RECEIVED VIA FAX OR EMAIL ONLY

FAX 951/275.5065

**25 hour cancellation policy on appointments 2 hours or less, and 49 hour cancellation on appointments lasting longer than 2 hours. Cancellations must be made during business hours. Weekend and Holidays NOT included. If cancellation is not made within the specified amount of time, the Customer will be billed for the total amount of time requested.*

Assignments more than 2 hours in duration will be scheduled and charged for 2 interpreters (TEAM INTERPRETING). EMERGENCY RATES WILL APPLY TO ALL REQUESTS MADE IN LESS THAN A 24 HOUR NOTICE OF SERVICE.