

NorCal Center on Deafness • Communication Services • (916) 349-7525  
Interpreter Request Form • FAX (916) 349-7578

Billing is based on a 1 hour minimum. Please be accurate when indicating START and END times.  
Subject to the availability of staff and subcontractors, communication services are provided on request.  
This form must be filled out legibly and completely. Illegible and incomplete forms will be returned.

Appointment Date: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM  
Day of the Week: M T W TH F SAT SUN (circle) End Time: \_\_\_\_\_ AM/PM  
Name of Requesting Agency: \_\_\_\_\_  
Name of Requestor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

TYPE OF SERVICES REQUESTED: (PLEASE CHECK)

- Sign Language Interpreter  Tactile Interpreter (Deaf/Blind)  
 Oral Interpreter  Video Interpreting  
 Real-Time Captioning—Transcription yes  no

ASSIGNMENT INFORMATION:

Name of Deaf/Hard of Hearing Consumer: \_\_\_\_\_  
Case Name/Case No.: \_\_\_\_\_  
Consumer Identification: (MRN/last 4 of SSN/DOB/P.O. No.): \_\_\_\_\_  
Name of Facility/Agency/Location: \_\_\_\_\_  
Appointment Address:  
Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Dept./Floor: \_\_\_\_\_ Cross Street: \_\_\_\_\_  
Doctor/Provider's Name: \_\_\_\_\_  
Specific Reason for Appointment: \_\_\_\_\_  
Does this appointment require a male or female interpreter? male  female  N/A   
Site Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

BILLING INFORMATION:

Bill to: Molina Healthcare, Inc. Attn: Health Education  
Division/Unit/Program Name: \_\_\_\_\_  
Street: 200 Oceangate, Suite 100 City: Long Beach Zip: 90802

REQUIRED SIGNATURE:

\_\_\_\_\_  
Authorizing Signature Date and Time  
\_\_\_\_\_  
Email Address Phone Number:

NorCal Center on Deafness does not bill third parties or the deaf or hard of hearing consumer.  
By signing this request, you are agreeing to the terms and conditions in the Service Agreement and to pay for services requested/provided.