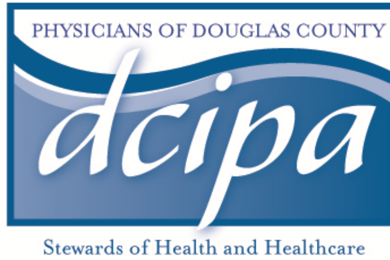

INTERPRETER PRIOR AUTHORIZATION FORM

To be filled out by the office staff and faxed to DCIPA. **1-541- 677-5881**

Patient name: ______________________________ DOB: ____________________

Insurance ID #: _______________ Patient's phone #: ______________________

PCP: ________________________

Referring doctor, if not the PCP: _____________________________

ICD-9 Code: __________

Foreign language requested: __________________________________

Signing requested: ________

Appointment date, time, and location: ___________________________________

Interpreter/signer requested if one has been used in the past. ________________

--*DCIPA will fax back the following information:*

Interpreter's name: ____

Interpreter's phone #: ___________________

Appointment confirmed by: ______________________ Date: _______________

Please notify the above interpreter/signer if the appointment date or time is changed.