FFS Provider Request for Interpreter Services
Cover Sheet and Service Authorization Form

Optum Fax: 1-866-220-4495
Optum Provider Line: 1-800-798-2254 Option 3, Option 4

For all interpreter requests please ensure the instructions below are completed on the **Service Authorization Form for Interpreter Services for Clients located on the next page.** For your convenience, request form is a form-filled document which allows providers to type in the required fields.

If required fields are not completed, request will not be processed and sent back as incomplete. Other fields that are not required by provider to complete will be completed by an Optum Staff. For questions contact the Optum Provider line at 1-800-798-2254 Option 5.

Instructions:

1. Provider **must** verify Medi-Cal eligibility for client. This is to ensure claims for services rendered can be processed and paid.

2. **Record client's address, ZIP code, Medi-Cal number, date of birth and gender in the boxes below. The fields highlighted are required to identify client in system.**

Client's Address:	
ZIP Code:	
Medi-Cal Number:	
Date of Birth:	
Gender:	

3. **Complete required fields on Service Authorization form (page 2 -- required fields are highlighted on form)**
   - **Client Information** (participant/client name, language requested, nature of appointment and age of children under 18)
   - **Service information Section A (date and requested time e.g. 9-10am)**
   - **Requester/Provider Information section – Name, Phone, Fax, Email and Service Site (requester/provider address)**

4. Request must be submitted **two business days** prior to initial appointment.

5. **Fax both cover sheet and request** directly to Optum at **1-866-220-4495**.

6. Do not fax directly to Interpreter Service Provider. Requests faxed to Interpreter Service Provider will not be processed.

7. Optum will set up interpreter services for the initial appointment only; provider will be responsible to request interpreter services for ongoing sessions. Provider must fax Service Authorization Form (second page only) directly to interpreter service provider for ongoing sessions.

Cancellation of appointment date will require new request form to be faxed to Optum.

County of San Diego
Health and Human Services Agency (HHSA)/ Child Welfare Services/ Probation/ All other

Service Authorization Form

Interpreter Services for Clients – Access and Authorization

Instructions:

1. To request interpreter services, please complete Client Information, Service Information Section A, and Requester Information and fax to selected interpreter service provider.
2. Complete Service Information Section B after services have been provided or canceled and fax to interpreter service provider. For ongoing requests, an authorized County representative should verify and submit the form for processing every week.
3. Retain original form at program site for record of services provided.

Please "X" the Provider Selected:

X	Service Provider	Phone	Fax	Type of Interpretation
☐	Interpreters Unlimited 541678 BPA	(800) 726-9891	(800) 726-9822	Oral / Spoken Language
☐	Deaf Community Services of San Diego, Inc.	(619) 398-2488	(619) 398-2490	American Sign Language

Client Information:

The County of San Diego, HHSA has authorized the following interpreting services for:

Name(s) of participant(s):	☐**Mr.** or ☐**Ms.**
If any participants are under age 18, please indicate age of minor(s):	
Language(s) requested:	
Nature of appointment:	
Interpreter gender:	☐**Male** or ☐**Female** Is gender request a ☐ **requirement** or ☐ **preference**?

I hereby attest that the date(s) of service recorded in Section B accurately reflect(s) treatment for this client (named above).

FFS Provider Printed Name	FFS Provider Signature	Date

Service Information:

Section A:			**Section B:**			
Date:	**Requested:** Start Time	**Requested:** End Time	**Actual:** Start Time	**Actual:** End Time	**Interpreter's Name:** (If Services were canceled, please write "Canceled")	**Verified By:** (Initial and Date)

Requester Information:

Requester		**Manager/ Designee Approved By**	
Name:		**Print Name:**	**Date:**
Phone:		**Signature:**	**Date:**
Fax:		**Service Site (if different from program address):**	
E-mail:			
Agency name:			
Program name and address:		**Site Contact**	
		Name:	
		Phone:	
County Department to be invoiced:		**E-mail:**	
COUNTY CONTRACT NUMBER BETWEEN PROGRAM AND COUNTY OF SAN DIEGO:			

NOTE: IT IS A HIPAA VIOLATION TO EMAIL ANY DOCUMENT CONTAINING PROTECTED HEALTH INFORMATION (PHI).