EK HEALTH
Transforming Managed Care℠

Interpretation Service Referral Form

Please submit form by fax to (408) 973-2508 or by email to interpretationservices@ekhealth.com

Client/Claimant/Patient:
Name (Last, First):
_____
Phone: _____
Address:
_____
_____
Language(s):
☐ Spanish
☐ Other(s): _____
Date of Birth: _____
SSN: _____
Claim/MRN/WCAB/Reference #:
_____

Appointment Information:
Service Date: _____
Service Time: _____
Appointment scheduled with:
(e.g. medical provider)
_____
Phone Number of Location:
_____
Address:
_____
_____
_____
Type of Appointment:
☐ Medical Visit
☐ Medical Evaluation QME
☐ Medical Evaluation AME
☐ Psychological Evaluation
☐ Deposition
☐ Other: _____

Interpreter:
☐ Non-Certified?
☐ Certified?

Applicant Attorney:
Name: _____
Phone: _____

Defense Attorney:
Name: _____
Phone: _____

Billing Information:
Company: _____
Contact: _____
Address:
_____
_____
_____
Phone: _____
Email: _____

Referred By:
☐ **Same as billing information**
Company: _____
Contact: _____
Address:
_____
_____
_____
Phone: _____
Email: _____

Comments:
_____
_____
_____

☐ **Authorized?**
☐ **On-going appointments authorized?**