☐ Member could not be validated in Tracker.

Interpreter Service Request Form

Please fax or email three business days in advance for all spoken languages and five business days in advance for American Sign Language (ASL).
Please type or write legibly in blue or black ink.

Please complete the entire form or your request may not be processed.

State:	**OH**		**IN**		**GA**	
Today's Date:			**Contact Phone #:**			
Name of Person Requesting Service:						
Email or Fax # for Scheduling Confirmation:						
Member Information						
Member Name:			**DOB:**			
Parent/Legal Guardian:						
CareSource ID #:					**Phone #:**	
Language Requested:			**Alternative Language, if any:**			
Additional Family Members (Add family members only when the same interpreter can be used.)						
Member Name:		**DOB:**		**CareSource ID #:**		
Member Name:		**DOB:**		**CareSource ID #:**		
Appointment Information						
Date of Service:						
Appointment Reason:						
Time of Appointment:		**Approx. Length of Appointment:**				
Facility Name:		**Office/Provider Name:**				
Address 1:						
Address 2:						
City, State, Zip:						
Facility Phone #:						
Any Specific Directions:						

Email or Fax Completed Forms for Processing

Email: InterpreterServices@CareSource.com

Fax: 1-937-396-3720

***CareSource requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to the member.**