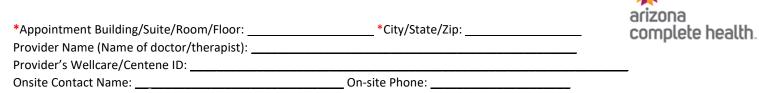




*Indicates required Field. Please complete all required fields or the request will not be fulfilled.

*Type of Interpreter					
□ American Sign Language					
□Tactile - Sign language received by sense of <i>touch</i> with one or both hands.					
	□ (PSE)				
•	gned English				
-	ilingual				
Foreign Language					
	panish				
□ Ar					
🗆 Fr	rench				
	ther				
	ect:	_			
*Interpreter Preference:					
□Fe		□Male			
	eferred				
	Required (may limit availability of interpreters)				
\Box No Preference					
	terpreter Name:				
Please understand	l if gender is a require	ment this can significan	tly reduce the total amount of av	ailable interpreters	
		0		•	
If the members preference is unavailable can any of the following be provided?					
□Video Remote Interpretation □Over the Phone (OPI)/ Tele-language					
*Caller Information:					
Calle Type (Member, Provider, Third Party):					
Caller Name:					
Callback number:					
*Person Needing Interpreter:					
*This person is a:					
□ WellCare/Centene Member □ Prospective Member □ WellCare/Centene Associate					
, -			,		
*Caller Type: Member/Provider*Name of Caller:					
*WellCare Member/Provider ID:*LOB:					
*Appointment Type (e.g., annual physical, physical therapy, surgery):					
*Phone Number: Alternative Phone Number:					
Email address:					
Appointment Deta	ails:				
*Appointment Date:*Appointment Time:*Time Zone:					
*Estimated Duration					
	*Appointment Type (e.g., annual physical, physical therapy, surgery):				
		rpreter needed for an ex			
	□Yes	□No	Duration:		
*Facility Name (Name of Hospital/Clinic):					
*Appointment Street Address:					



Please email the completed form to InterpreterRequests@centene.com

We cannot guarantee an interpreter if the request is received less than 5 business days before the appointment. Requests for interpreters cannot be made more than 30 days in advance of the scheduled appointment.

Quality care is a team effort. Thank you for playing a starring role!