Sign Language Interpreter Request Form
UnitedHealthcare
State of RI Members Group # 707837
Fax form to: Cindy Uva
401-732-7211
Phone call is appreciated as well: 401-732-7109

Requestor Information:
Today's Date_____
Provider's Full Name_____
Phone# and extension_____
Provider's Address_____
Office Contact Person_____

Member Information:
Member's
Name_____D.O.B_____
Subscriber ID or SSN#_____
Patient's Name_____DOB_____
Communication Preference(ASL, Signed English, tactile, etc…

Name of Specific Interpreter requested (if
one)_____

Service Information:
Date of Service:_____
Time Start:_____ Time End _____
Office Locaton: _____ Suite /Floor _____
City_____
Zip Code _____
Nature of Visit _____

Two weeks notice appreciated
Please ask Member to sign Assignment of Benefits Form