PLEASE SIGN AND FAX TO 212-255-8409 OR EMAIL TO Interpretingstaff@genevaworldwide.com

Interpreter Request Form for DC Medicaid Fee-for-Service Beneficiaries

ASSIGNMENT INFORMATION	
DATE REQUESTED:	**LANGUAGE:**
ASSIGNMENT DATE AND TIME:	**PROVIDER NAME:**
PROVIDER ID:	**PROVIDER ADDRESS:**
PROVIDER PHONE:	**PROVIDER FAX:**
PATIENT INFORMATION	
NAME:	**MEDICAID ID NUMBER:**
TELEPHONE NUMBER:	**DOB:**
PATIENT ADDRESS:	

THE ABOVE MENTIONED SERVICE WILL BE BILLED AT THE CONTRACTUAL RATE ESTABLISHED BY DHCF WITH A ONE HOUR MINIMUM CHARGE BILLED IN 15 MINUTE INCREMENTS THEREAFTER.

CANCELLATION POLICY: GWW REQUIRES 24 HOURS NOTICE. IF CANCELLED IN LESS THAN 24 HOURS, ASSIGNMENT WILL BE BILLED FOR A ONE HOUR MINIMUM.

IF YOU HAVE QUESTIONS ABOUT DC MEDICAID LANGUAGE ACCESS BENEFITS, OR HAVE TROUBLE ACCESSING SERVICES, PLEASE CONTACT VALENTINE BREITBARTH, DC DEPARTMENT OF HEALTH CARE FINANCE, DELIVERY MANAGEMENT ADMINISTRATION AT 202.299.2117 OR VALENTINE.BREITBARTH@DC.GOV.

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