



**INTERPRETIVE SERVICES  
APPOINTMENT RECORD**

**Use for workers' compensation or crime victim claims.**  
Send original to insurer. Interpreter: Keep photocopy for your records.

Date of Injury	Claim Number
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Claimant's phone #	Claimant's name (last, first, middle initial)
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**APPOINTMENT INFORMATION May be completed by Interpreter or Language Agency**

Name of scheduled health care / vocational provider	Appointment date	Start time
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Street address of health care / vocational provider	City	State
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Type of appointment: Please check below  <input type="checkbox"/> Doctor <input type="checkbox"/> Vocational <input type="checkbox"/> PT or OT <input type="checkbox"/> Pharmacy <input type="checkbox"/> Hospital <input type="checkbox"/> Diagnostic <input type="checkbox"/> PCE <input type="checkbox"/> IME <input type="checkbox"/> Other	Telephone number (      )	Language requested
	Comments	

**INTERPRETER INFORMATION Completed by Interpreter**

Name of interpreter (last, first, middle initial)	Interpreter's Provider Number
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Language agency's name, if applicable	Agency's Provider Number
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Interpreter's travel starting address	City	State
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Appointment address	City	State
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Return or next appointment location	City	State
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Mileage to appointment	<b>Important:</b> Submit Mileage documentation printout from a software mileage program and name of software program	<b>Group service information</b> If this was a group service, please indicate number of total persons served in the group and divide service time and mileage accordingly.  Indicate total number of persons served in the group:	
Mileage to next appointment			
Interpreter's Total Mileage			
Interpreter's arrival time	Scheduled start time	Completion time	Total billable time Minutes:

Date	By signing this document, I certify that I have provided the interpretive services indicated above. Signature
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**INTERPRETER SERVICES VERIFICATION Completed by Health Care of Vocational Provider or their designee. Do not sign unless information above has been completed.**

Comments:

Send original to insurer. Interpreter keep photocopy for your records.	Name of person verifying services (print)	Title
	Signature of person verifying services	Date

**CLAIM INFORMATION** (submit original to insurer) Do not staple documentation to bill forms. Send documentation separately from bills to:

<b>State Fund</b> Department of Labor and Industries PO Box 44291 Olympia, WA 98504-4291 1-800-848-0811 360-902-6500 FAX 360-902-4566      360-902-4567 360-902-5230      360-902-6440 360-902-4292      360-902-4565 360-902-6252      360-902-6100	<b>Crime Victim Compensation</b> Department of Labor and Industries PO Box 44520 Olympia, WA 98504-4520 1-800-762-3716 360-902-5377 FAX 360-902-5333	<b>Self-insurer</b> Varies – Call 360-902-6901 to obtain Insurer's phone number and address OR See Self-insurer list at: <a href="http://www.lni.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp">http://www.lni.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp</a>
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## **Instructions for Completing INTERPRETIVE SERVICES APPOINTMENT RECORD**

**Submit original to the insurer.**

**Do not staple documentation to bill forms. Use the proper address on bottom of other side to send documentation.**

*Some Guidelines to complete form.*

**Claim Number:** This is our tracking device. Please ensure the Claim Number of the client is accurate.

**Name of scheduled provider:** This may be a health care or vocational provider with whom client is scheduled.

**Comments:** Any special request information or other instructions.

**Interpreter Provider Number:** Enter the L&I state fund or Crime Victims assigned provider number for the interpreter.

**Language Agency Provider number:** Enter the L&I state fund or Crime Victims assigned provider number for the language agency.

**Mileage to appointment:** Calculate the miles from the origins of the trip to the destination. Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program

**Mileage from appointment:** This is the return mileage. Mileage must be split between ALL clients of a group and between clients if there are multiple appointments in one day. If services are delivered in multiple locations for same client, mileage is payable but not the travel time between locations. Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program

**Total billable time:** Enter the total billable time (excluding travel time between appointments). Bill from the arrival time or scheduled start time-whichever is LATEST. Interpreter's TRAVEL time is NOT payable.

**Group Services:** If more than one person was served, please enter the information. Group service time must be divided between ALL clients in the group. After calculating the total mileage and billable time, divide by the total number of clients served in that appointment.

**Comments:** Please enter any additional information about the services or appointment as needed.

**IMPORTANT:** Health care or vocational provider or designated staff must sign to verify services.

**IMPORTANT:** Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program