

LAMP  
Toll Free: 866-948-7133  
Office Hours: 8:00 AM - 5:00 PM  
Monday through Friday  
[www.lampagency.com](http://www.lampagency.com)



Int: \_\_\_\_\_  
Conf. Call: \_\_\_\_\_  
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## Telehealth Interpreter Request

### Fax to 314-842-1303

This document contains confidential information that is protected by federal and state laws. If you have received this document in error, please help us to protect the confidentiality of the information by contacting us at the number above for further instructions.

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ AM / PM

REQUESTING PARTY: \_\_\_\_\_ PROVIDER: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_

PATIENT NAME: (First / Last) \_\_\_\_\_

MEMBER INSURANCE: \_\_\_\_\_ ID#: \_\_\_\_\_

PATIENT PHONE #: \_\_\_\_\_ M / F DOB: \_\_\_\_\_

APPOINTMENT LOCATION-NAME & IP ADDRESS: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

EXPECTED DURATION OF APPOINTMENT: \_\_\_\_\_

HEALTH FACILITY CONTACT PERSON: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSON COMPLETING FORM: \_\_\_\_\_ PHONE: \_\_\_\_\_

(If Different from Contact Person)

NOTES: Please include NPO Instructions, if any.