

LAMP
Toll Free: 866-948-7133
Office Hours: 8:00 AM - 5:00 PM
Monday through Friday
www.lampagency.com



Int: _____
Conf. Call: _____
FOR LAMP USE ONLY

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.

