

Language Assistance Request Form

Fax to: Blue Shield Translation Liaison at **(248) 733-6331**
Number of pages (including cover) =

RE: Language Assistance Request on behalf of a Blue Shield Member.

Use this form for enrollees of Blue Shield of California or Blue Shield of California Life & Health Insurance Company.

This is a request for written translation of specific document(s) only

Date of request:	
From: (Name and organization):	Phone number:
Subscriber I.D. Number:	Subscriber name:
Patient Name:	Patient date of birth:
Requested Language:	Patient contact phone number:
If our Translation Liaison has questions, whom should we contact?	Provider contact number:
Brief description of document to be translated (please attach copy of document):	
<input type="checkbox"/> This request is urgent. Note: Providers must forward request from member to Blue Shield within one business day.	
<input type="checkbox"/> This request is non-urgent. Note: Providers must forward request from member to Blue Shield within two business days.	
Please notify me at _____ when this request has been fulfilled. (phone number where we can reach you)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

This facsimile transmission may contain protected and privileged, highly confidential medical and/or legal information. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, please immediately notify the sender. Blue Shield of California will arrange to retrieve the fax at no cost to you. Thank you for your help in maintaining appropriate confidentiality.