blue of california

Language Assistance Request Form

Fax to: Blue Shield Translation Liaison at **(209) 371-5838**

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

An Independent Member of the Blue Shield Association

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):	
□ **This request is urgent**. Note: Providers must forward request from member to Blue Shield within one business day. □ **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) □ Yes □ No	