MAGELLAN HEALTH SERVICES
Getting Better All the Time

CALIFORNIA PROVIDER
LANGUAGE CAPABILITY VERIFICATION FORM

If you are fluent in a language other than English, please describe your capabilities below. To be considered fluent, a person must:

(i) Be a native speaker or have at least two years' experience using a language in a health care setting, and
(ii) Understand behavioral health terms and concepts in the other language(s) in addition to English.

Complete this document and fax it to 314-387-5587, 314-387-5588 or 314-292-1064; or mail it to Magellan Health Services, Attn: Network Services, 14100 Magellan Plaza, Maryland Heights, MO 63043.

If you rely on office staff or other providers in your office, you must **re-submit this form every quarter**, whether or not there are changes to report. Please keep a blank copy of this form for future submissions; if you need another copy of the form, call our Provider Services Line at 1-800-788-4005 or visit www.MagellanHealth.com/provider (click "State- and Plan-Specific Information," then "State-Specific," then "California").

Practitioner name	
Magellan MIS number	
Practice or Group name, if other than Practitioner's name	
Office address	/ /
Practitioner's native language	☐English ☐Chinese ☐Hmong ☐Vietnamese ☐Tagalog ☐Spanish ☐American sign language ☐Other: _____
Language(s) in which **Practitioner** can communicate *fluently* and understand in the course of providing clinical services	☐English **only** ☐English ☐Chinese ☐Hmong ☐Vietnamese ☐Tagalog ☐Spanish ☐American sign language ☐Other: _____
Language(s) in which 1 or more **office staff** can communicate *fluently* and understand in interacting with Practitioner's patients or clients	☐No office staff ☐English **only** ☐English ☐Chinese ☐Hmong ☐Vietnamese ☐Tagalog ☐Spanish ☐American sign language ☐Other: _____
Language(s) in which 1 or more **other practitioners** can communicate *fluently* and understand in the course of providing clinical services	☐No other practitioners in office ☐English **only** ☐English ☐Chinese ☐Hmong ☐Vietnamese ☐Tagalog ☐Spanish ☐American sign language ☐Other: _____
If this is a follow-up form, please indicate the quarter and year	☐Jan-Mar ☐Apr-June ☐July-Sept ☐Oct-Dec ☐2009 ☐2010 ☐2011 ☐2012 ☐20_____

I certify that the information in this document is true and correct. If am relying on the language capabilities of office staff and/or office colleagues for language capabilities in connection with a language in which I lack proficiency, I agree to submit **quarterly updates** of changes in the information stated above.

_____ _____ _____

Provider signature | Print Name | Date

Please be sure to SIGN and DATE this form. This document will not be valid without a signature. Your language capability information will be included in our provider directory. If this form is not returned, no information about your language capabilities will be included in our provider directory.

THANK YOU FOR YOUR PROMPT RESPONSE!

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