Intercultural Mutual Assistance Association, INC
2500 Valleyhigh Drive NW Rochester, MN 55901
Phone 507 289 5960 Fax 507 289 6199
nermina.ikanovic@imaa.net www.imaa.net

Please reference this invoice number on all checks and correspondence.

IMAA PROFESSIONAL LANGUAGE SERVICES

WORK ORDER/ INVOICE

Requesting Agency Name:_____

Language: _____ Interpreter**:** _____

☐ **South Country Health Alliance**

☐ **UCare Provider #:** 182813

☐ **Blue Plus Provider #:** 07L32IM

Client and Appointment Information

* First Name:	* Last Name:
* M or F:	* DOB:
* Client Telephone:	ID #:
Client Address: City/State/Zip Codes:	
* Appointment Date:	* Practitioner Name:
* Appointment Time:	Approximate Length:
Department:	

Requesting Agency Information

* Agency Address:	
* Phone Number:	Fax Number:
Address of Appointment (if different from above):	
Requested by:	

*** Check the following box:**

☐Office Visit ☐ No Show ☐Home Visit ☐Written Translation ☐Conference Call ☐Emergency Room

To Be Completed at Job Site

* Arrival Time:	*Departure Time:	Total:
* Travel Outside of Olmsted County : (Circle One) YES Or NO		

* Interpreter Signature: _____ * Date: _____

* Verifying Staff Signature: _____ * Date: _____

Official Use Only:

Please remit payment of $ _____ to IMAA 2500 Valleyhigh Drive NW, Rochester, MN 55901

Federal ID # 41-1497753 PAYMENT DUE WITHIN 45 DAYS

Please contact IMAA Operations Manager if you have any questions regarding this billing. Thank You!

IMAA Signature ----------

Comments:

_____

_____

☐ Code 76

Date ----------

_____ Travel Time $ _____

_____ AM $ _____

_____ PM $ _____

_____ WKND $ _____

Interpreter: All Work Orders must be signed and the information that has an * next to it must be completed for payment.
White - Billing Copy • Yellow – Office Copy • Pink - Interpreter