



Dear Participating Provider:

March Vision Care is asking for your assistance in fulfilling the requirements set forth in the Department of Managed Health Care's Language Assistance Program ("LAP") Regulations (Section 1300.67.04 of the California Code of Regulations, Title 28). Please complete the following Language Capability Verification Form to attest that you and/or your office staff are bilingual and fluent in languages other than English. If you have questions please contact March Vision Care at (888) 493-4070, Option 3.

LANGUAGE CAPABILITY VERIFICATION FORM

To ensure that patients will have accurate information on provider's and office staff language capability, please fill out this document and fax it back to (877) 627-2488. Please make sure to SIGN this document. **This document will not be valid without a signature.** Language information will be printed in a provider directory.

<u>PROVIDER NAME:</u>	
<u>LICENSE:</u>	
<u>PRIMARY SPECIALTY:</u>	
<u>CLINIC NAME:</u>	
<u>OFFICE ADDRESS:</u>	
<u>PHONE:</u>	
FAX:	
LANGUAGE(S) FLUENTLY SPOKEN BY PROVIDER:	English,
LANGUAGE(S) FLUENTLY SPOKEN BY OFFICE STAFF:	English,

I certify that the information in this document and any attached documents is true and correct.

Provider Signature/Provider Staff

Print Name

Date

THANK YOU FOR YOUR PROMPT RESPONSE!