

This form should be used to request outpatient treatment.  Revised 11.1.18	<b>COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN</b> <b>OUTPATIENT AUTHORIZATION REQUEST- PSYCHIATRY</b>  Please check: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuing Request <b>PLEASE SUBMIT DEMOGRAPHIC FORM W/INITIAL REQUESTS</b>	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800) 798-2254, option #3
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<i>CONFIDENTIAL</i>	<b>Client Information</b>	<i>CONFIDENTIAL</i>
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Client Last Name:	First:	Middle:	Medi-Cal CIN #:	Birth Date:	Current Health Plan:
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If Child, current IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No	San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, contact name and number:
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Current Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, PSW name and number:
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If Hx of CWS, when and why?

**DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations**

Primary Diagnosis:	ICD 10 Code:
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Other Diagnoses (Mental & Physical Health):

**Presenting Mental Health Problem, Symptoms, Functional Impairment**

Current symptoms and severity: How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis? Please list symptoms with frequency and duration.

Hx of Trauma and/or Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain:
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Substance Use: <input type="checkbox"/> N/A <input type="checkbox"/> Hx <input type="checkbox"/> Current	Drug(s) of choice:
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Describe current substance use impact on functioning:

**Medications (Psychiatric, Medical, & OTC medications) Have you checked CURES:  Yes  No**

Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support): How have you coordinated with these providers? If not, please explain:

Progress:  N/A (Initial Request)  Near completion  Improving  Stabilizing  Regressed due to new stressor  Little/no progress

Expected length of treatment:

Date of 1<sup>st</sup> Appointment/Assessment with you:

Referrals made to other community supports and/or aftercare plans for client's recovery:

*(Signed client plan required in client's chart within 30 days of commencing treatment)*

**Provider Requested Authorization Units – Please Sign Below**

On Begin Date of Sessions, Client is:  Adult  Child

Interpreter needed for these sessions:  No  Yes, Language: \_\_\_\_\_

Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
<b>Outpatient Office Visit</b> DO/MD/PNP only – E/M codes & therapy (max 26)				
DO/MD/PNP only – Psychotherapy Add on Code (max 26)				
Case Management				
Team Conference				

**Provider Information**

Name/Licensure:

Phone:

Provider Signature:

Date:

Fax:

If Modified or Denied,  
Date Provider Called:

Date NOA sent:

If Group Practice, name of Group:

**For Optum Care Advocate**

*If Request Modified or Denied, below sessions were authorized:*

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature