Optum

Inpatient Auth Request Fax Cover Sheet

Call Provider Line at 800-798-2254, Option 3
Then, fax to 866-220-4495

Facility Information	
Date: Hospital Name: Client Name:	# of Pages (including cover sheet):
Intake Point of Contact (name): Intake Phone #: Intake Fax #: UR Point of Contact (name): UR Phone #: UR Fax #:	Facility Type: ☐Fee For Service ☐Short Doyle ☐Psychiatric Health Facility
Admission & Insurance Information (required upon initial request and as changes occur):	
Admit Date:	Medi-Cal or SSN:
Attending Physician:	Client DOB:
Legal Status: (72hr/ 14-day/ 30-day/ T-Con / P- Con/ Voluntary (hold required for SB43)) Reason for MH Admission: ☐ DTS ☐ DTO ☐ GD/MH ☐ OTHER OR Reason for SB43 Admission: ☐ GD/SUD only and ☐ CDRH or ☐ IP BHU	San Diego Medi-Cal: ☐ Yes ☐ No If Medicare/OHC – Start date of Medi-Cal Coverage: (Must include EOB or Letter of Non-Coverage)
Admit Auth	**Continued Auth**
☐ MH Admit Auth: # Days requested (up to 3 Acute, up to 1 Admin): Acute #: Start Date Acute: Admin #: Start Date Admin: OR ☐ SB43 Admit Auth: # Days requested (up to 3 Acute): Acute #: Start Date Acute: **Documents Required:** • Complete Face Sheet • Admission Orders • Initial Plan of Care • If MH Admin Day, Disposition Plan/Location – Call Logs (if applicable)	☐ MH Continued Auth: # Days Requested (up to 4 Acute, up to 7 Admin): End date of previous authorization: Acute #: Start Date Acute: Admin #: Start Date Admin: OR ☐ SB43 Continued Auth (for IP BHU Hospital called and no CDRH bed is available): ☐ IP BHU or ☐CDRH # Days requested (up to 4 Acute, up to 7 Admin): End date of previous authorization: Acute #: Start Date Acute: Admin #: Start Date Admin: **Documents Required:** • Continued Plan of Care • Additional Information • If MH Admin Day, Disposition Plan/Location Call Logs (if applicable)
☐ **Expedited/Informal Appeal or Clinical Consultation (submit within 2 business days of denial fax date)**	**Discharge**
First denied date of service(s) on denial (if applicable): If requesting Acute or Admin days, utilize Admit/Continued Auth box **Documents Required:** • Updated Plan of Care/Additional Information	☐ MH Discharge ☐ SB43 IP BHU Discharge ☐ SB43 CDRH Discharge Admission Date: Discharge Date: Dates of Acute Days: Dates of Admin Days: **Documents Required:** • Discharge Plan/Summary

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