This form should be used to request outpatient treatment.

Revised 10.6.21

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN
OUTPATIENT AUTHORIZATION REQUEST

Please check: ☐ Initial Request ☐ Continuing Request

PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS

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 then 3

CONFIDENTIAL **Client Information** *CONFIDENTIAL*

Client Last Name:	First:	Middle:	Gender: ☐ M ☐ F ☐ O	Client Ethnicity:
Click here to enter text.				

Age:	DOB: 00/00/0000	Living Situation: ☐ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐Other, with whom? Click here to enter text.	Justice System Involvement: ☐ N/A ☐ Yes If Yes, explain:

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
Current Health Plan: Choose an item.	If Child, current IEP: ☐ Yes ☐ No School District:	San Diego Regional Center Client: ☐ Yes ☐ No

Current Referral by Child Welfare Services: ☐Yes ☐No:	If Yes, PSW name and number:

If Hx of CWS, when and why?

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

Primary Diagnosis Description:	ICD 10 Code:

Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current Symptoms (please list w/ frequency and duration):

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:

Hx of Trauma and/or Abuse? ☐ Yes ☐ No	If Yes, explain: Required if "Yes"
Substance Use: ☐ N/A ☐ HX ☐ Current	Drug(s) of choice: Required if "Current" or "HX"

Describe current substance use impact on functioning:

Required if "Current" substance use

Current Risk Assessment:	Suicidal -	☐ N/A	☐ Ideation	☐ Plan	☐ Intent	☐ History of harming self
	Homicidal -	☐ N/A	☐ Ideation	☐ Plan	☐ Intent	☐ History of harming others

Client Strengths (i.e., motivated, employed, strong social supports):

Medications (Psychiatric, Medical, & OTC medications)

Name of Medication w/ Dosage or N/A:

Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Treatment

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.):

If Group Therapy, # Participants: Click here to enter text. Group Topic/Focus:

Treatment plan with measurable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both):

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:

If Initial Request, date of Assessment with you:

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

Client Signature

******I, (print name) Click here to enter text.participated in the development of this plan and received a copy.*

Client Signature: ____ *Date:* Click here to enter text.

(Signed Client Plan required in Client's Chart within 30 days of commencing treatment; may use separate form than the OAR)

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: ☐ **Adult** ☐ **Child**

Interpreter needed for these sessions: ☐**No** ☐**Yes, Language:**Click here to enter text.

Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
Psychotherapy (max 12)				
Group Psychotherapy (max 12, specify length of session)				
Team Conference (99366 or 99368)				
Other:				
Other:				

Provider Information

Name/Licensure:

Phone:

Provider Signature: Date:Click here to enter text.

Fax:

If Group Practice, name of Group:

If Modified or Denied, Date of NOA: ______________________

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

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