

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: <input type="checkbox"/> Initial Request <input type="checkbox"/> 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
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CONFIDENTIAL	Client Information	CONFIDENTIAL
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Client Last Name:	First:	Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	Client Ethnicity:
Click here to enter text.				

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

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
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Current Health Plan: <small>Choose an item.</small>	If Child, current IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No School District:	San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Current Referral by 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 Description:	ICD 10 Code:
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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? <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:

Current Risk Assessment:	Suicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self Homicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming others
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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

*****, (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