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| County of San Diego Mental Health Plan  **Ancillary Specialty Mental Health Services (SMHS) Request**  Submitted by the Day Services Provider to Optum in Coordination  with the Ancillary Specialty Mental Health Provider (SMHP)   |  |  | | --- | --- | | **Please Check:** | **Initial Request (within 5 business days of Ancillary Start date)** | | **Continuing Request (completed on Day Services UM cycle)** | | | | | | | | | **FAX TO: (866) 220-4495**  Optum Public Sector San Diego  Phone: (800) 798-2254, Option 3, then Option 4 | |
| **COMPLETED BY DAY SERVICES PROVIDER** | | | | | | | | | |
| **CLIENT INFORMATION** | | | | | | | | | |
| **Client Name**: | | **Client ID**: | | | | | **Client Date of Birth:** | | |
| **DAY PROGRAM INFORMATION** | | | | | | | | | |
| **Legal Entity:**  **Fax**:        **Day Services Authorization Start date:** | | **Program Name:**  **Unit#:**  **\*Day Services Authorization End Date:** | | | | **Phone**:  **Day Program Subunit#**: | | | |
|  | | | | | | | | | |
| **COMPLETED BY ANCILLARY ORGANIZATIONAL PROVIDERS (IF FEE FOR SERVICE PROVIDER LEAVE BLANK)** | | | | | | | | | |
| **ORGANIZATIONAL SPECIALTY MENTAL HEALTH SERVICES PROVIDER (SMHP) INFORMATION** | | | | | | | | | |
| **Legal Entity:**  **Fax**: | | **Program Name:**  **Unit#:** | | | | **Phone**:  **Program Subunit#**: | | | |
|  | | | | | | | | | |
| **TO BE COMPLETED BY ANCILLARY FEE FOR SERVICE PROVIDERS (IF ORGANIZATIONAL PROVIDER LEAVE BLANK)** | | | | | | | | | |
| **FEE FOR SERVICE (FFS) SMHP INFORMATION** | | | | | | | | | |
| **PROVIDER LAST NAME:** | **PROVIDER FIRST NAME**: | | | **PHONE:** | | | | | **FAX**: |
|  | | | | | | | | | |
| **COMPLETED BY ANCILLARY ORGANIZATIONAL OR FFS PROVIDER** | | | | | | | | | |
| **AUTHORIZATION REQUEST FOR ANCILLARY SMHS IN ADDITION TO DAY SERVICES** | | | | | | | | | |
| **SELECT THE AMOUNT OF ANCILLARY SMHS REQUESTED (Inclusive of all Individual, Collateral, ICC, IHBS, Group, Rehab, Case Management or other covered SMHS provided by the Ancillary SMHP):** | | | | | | | | | |
| Sessions Requested Per Week  Ancillary Authorization Start Date:  Ancillary Provider Assignment Start Date: | | | Ancillary Authorization End Date:  ***\*Matches the Day Services Authorization End Date Listed Above*** | | | | | | |
| **MEDICAL NECESSITY CRITERIA FOR ANCILLARY SMHS** | | | | | | | | | |
| **Ancillary Service Necessity Criteria - check all that apply and explain (choose at least one):**  Requested service(s) is not available through the day program. Describe why service is not available:  Continuity or transition issues make these services necessary for a time limited interval. Describe the need:  These concurrent services are essential to coordination of care. Describe why services are essential: | | | | | | | | | |
| **Ancillary Organizational/FFS SMHP (Print):**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Day Service Provider (Print):**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **Credentials:**  **Date:**  **Credentials:**  **Date:** | | | | |

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| **FOR OPTUM USE ONLY**  **Optum reviews and retains. Optum Authorization Determination is documented on the Prior Authorization Day Services Request (DSR) form and is viewable to the Day Service Provider and SMHP within 5 business days of Optum receipt in the CCBH Clinicians Home Page Authorizations Tab.** |