Outpatient Authorization Request
Medication Services

To request authorization fax or mail to:
Optum Public Sector San Diego
PO Box 601370
San Diego, CA 92160-1370
Fax: (866) 220-4495 Phone: (800) 798-2254, option 3 then 4

*** Indicates a required field**

***SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS**

Please check: ☐ Initial Request ☐ Continuing Request (Client seen by you within the last 6 months)

Client Information

*Client Name:	Gender: ☐ M ☐ F ☐ O	Age:	*DOB:
*Client Ethnicity:	*Medi-Cal #:		

*Living Situation: ☐ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐ Other, with whom?

San Diego Regional Center Client: ☐ Yes ☐ No

Current Employment /School Status: ☐ Employed ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Seeking Work ☐ Not in Labor Force ☐ Unknown ☐ Other

*If Client under 21, current Referral by Child and Family Well-Being (CFWB) Department: ☐ Yes ☐ No
*If Yes, PSW name and number:

If History of CWS/CFWB, when and why?

Diagnosis and Other Clinical Considerations

*Primary DSM/ICD Diagnosis with Specifier:	*ICD Code:

Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problems and Symptoms

*Current Symptoms (List the frequency and duration) that result in impairment:

*Problem List: ☐ Reviewed/updated ☐ No changes Date Problem List reviewed/updated:

Significant Impairment

***Distress, Disability, or Dysfunction in:**	**Yes**	**No**
Social/Relational	☐	☐
Occupational/Academic	☐	☐
Other Important Activities	☐	☐
Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning	☐	☐
Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21)	☐	☐

***Explain Significant Impairment:**

***History of Trauma and/or Abuse:** ☐ Yes ☐ No
*If Yes, explain:

***Substance Use:** ☐ No ☐ History ☐ Current *Drug(s) of choice:

*If current substance use, describe impact on functioning:

Medications (Psychiatric, Medical & OTC)

***Have you checked CURES: ☐ Yes ☐ No**

*Name of Medication:	*Medication Dosage & Frequency:	Name of Medication:	Medication Dosage & Frequency:

*If no medications, explain plan for medications/or need for medication monitoring:

Provider Requested Authorization Units
<u>Important:</u> You must be a current contracted provider through Optum Public Sector San Diego to be able to obtain authorization for services and payment.

Interpreter needed for these sessions: ☐ No ☐ Yes, Language:

If Initial Request, First Date of Assessment:

☐ 90792 ☐ 99202-99205

Treatment	*Begin Date of Sessions	*Number of Sessions	*Frequency Number of Sessions per Week/Month/Year
Outpatient Office Visit DO/MD/PA/PNP only E/M codes and therapy (max 26)			
DO/MD/PA/PNP only Psychotherapy Add on code (max 26)			
MD/DO Medical Team Conference (99367, max 1 unit per day)			
PNP/PA Medical Team Conference (99366 or 99368)			
Other:			
Targeted Case Management (T1017, 1 unit = 15 minutes)			

Targeted Case Management will focus on:

☐ Medical, Explain:

☐ Social, Explain:

☐ Educational, Explain:

☐ Other Services, Explain:

Provider Information

*Name/Licensure:

*Phone:	Fax:
*Provider Signature:	*Date:

If Group Practice, Name of Group:

☐ Check here to waive verbal notification of authorization determination for initial requests. Written notification will be sent for all requests.

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **Optum Reviewed OAR**
☐ **Client meets SMHS medical necessity criteria. Authorization request approved. Start Date: _____**
☐ **Initial Requests: Date of verbal notification to Provider: _____**
☐ **Provider waived verbal notification**
Name of Optum Medical Director consulted and date: **_____**
Authorization request is ☐ Denied ☐ Modified ☐ Reduced ☐ Terminated ☐ Suspended
Date of verbal notification to Provider: ____
Date NOABD & Letter of Determination issued to Beneficiary and Provider: _____
NOABD clinical consultation summary & reason for denial: _____
_____

Optum Clinician Name and Date: