A close up of a logo

Description automatically generated

**Outpatient Authorization Request**

**Psychotherapy**

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 | | | | | | | | | | | | | |
| Justice System Involvement:  N/A  Yes If Yes, explain: | | | | | | | | | | | | | |
| \*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: | | | | | | | | | |
| **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: | | | | | | | | | | | | | |
| **\*Current Risk Assessment:** | | Suicidal:  No  Ideation  Plan  Intent  History of harming self | | | | | | | | | | | |
| Homicidal:  No  Ideation  Plan  Intent  History of harming others | | | | | | | | | | | |
| **Medications (Psychiatric, Medical & OTC)** | | | | | | | | | | | | | |
| Name of Medication: | Medication Dosage: | | | | Name of Medication: | | | | | | | Medication Dosage: | |
|  |  | | | |  | | | | | | |  | |
|  |  | | | |  | | | | | | |  | |
|  |  | | | |  | | | | | | |  | |
| No Medications | | | | | | | | | | | | | |
| **Interventions** | | | | | | | | | | | | | |
| List Interventions (CBT, DBT, etc.): | | | | | | | | | | | | | |
| Group Therapy, Number of participants:       Group Topic: | | | | | | | | | | | | | |
| **Provider Requested Authorization Units**  **Important: 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:** | | | | | | | | | | | | | |
| **Treatment** | | | **\*Begin Date of Sessions** | | | | **\*Number of Sessions** | | **\*Frequency Number of Sessions per Week/Month/Year** | | | | |
| Psychotherapy  (max 1 per day, max 12 total) | | |  | | | |  | |  | | | | |
| Group Psychotherapy  (max 12, specify length of session) | | |  | | | |  | |  | | | | |
| Other: | | |  | | | |  | |  | | | | |
| Team Conference  (99366 or 99368, max 1 unit per day) | | |  | | | |  | |  | | | | |
| 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**: |