

**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**: |