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 **<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:			
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: