



Outpatient Authorization Request Psychotherapy

To request authorization fax or mail to:

Optum Public Sector San Diego

PO Box 601340

San Diego, CA 92160-1340

Fax: (866) 220-4495 Phone: (800) 798-2254, option 3 then 4

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	Age:	DOB:	Client Ethnicity:
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Living Situation: <input type="checkbox"/> Homeless <input type="checkbox"/> Alone <input type="checkbox"/> ILF <input type="checkbox"/> B&C <input type="checkbox"/> SNF <input type="checkbox"/> Other, with whom?	Medi-Cal #:
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San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Employment /School Status: <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Work <input type="checkbox"/> Not in Labor Force <input type="checkbox"/> Unknown <input type="checkbox"/> Other
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Justice System Involvement: N/A Yes If Yes, explain:

Current Referral by Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, PSW name and number:	If History of CWS, when and why?
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Diagnosis and Other Clinical Considerations

Primary DSM/ICD Diagnosis with Specifier:	ICD Code:
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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	<input type="checkbox"/>	<input type="checkbox"/>
Occupational/Academic	<input type="checkbox"/>	<input type="checkbox"/>
Other Important Activities	<input type="checkbox"/>	<input type="checkbox"/>
Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning	<input type="checkbox"/>	<input type="checkbox"/>
Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21)	<input type="checkbox"/>	<input type="checkbox"/>

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: <input type="checkbox"/> No <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self			
	Homicidal: <input type="checkbox"/> No <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self			
Medications (Psychiatric, Medical & OTC)				
Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:	
<input type="checkbox"/> No Medications				
Interventions				
List Interventions (CBT, DBT, etc.):				
<input type="checkbox"/> Group Therapy, Number of participants:		Group Topic:		
Provider Requested Authorization Units				
Interpreter needed for these sessions: <input type="checkbox"/> No <input type="checkbox"/> 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	Optum Clinician Signature: (For Optum Care Advocate Signature – Internal Use Only)
Psychotherapy (max 12)				
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:				
<input type="checkbox"/> Medical, Explain:				
<input type="checkbox"/> Social, Explain:				
<input type="checkbox"/> Educational, Explain:				
<input type="checkbox"/> Other Services, Explain:				
Provider Information				
Name/Licensure:			Phone:	
Provider Signature:		Date:	Fax:	
If Group Practice, Name of Group:				