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| County of San Diego Mental Health Plan**Ancillary Specialty Mental Health Services (SMHS) Request** Submitted by the Day Services Provider to Optum in Coordination with the Ancillary Specialty Mental Health Provider (SMHP)

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|  **Please Check:** | [ ]  **Initial Request (within 5 business days of Ancillary Start date)** |
| [ ]  **Continuing Request (completed on Day Services UM cycle)** |

 | **FAX TO: (866) 220-4495**Optum Public Sector San DiegoPhone: (800) 798-2254, Option 3, then Option 4 |
| **COMPLETED BY DAY SERVICES PROVIDER** |
| **CLIENT INFORMATION** |
|  **Client Name**:        | **Client ID**:        |  **Client Date of Birth:**        |
|  **DAY PROGRAM INFORMATION** |
|  **Legal Entity:**       **Fax**:       **Day Services Authorization Start date:**       | **Program Name:**      **Unit#:**      **\*Day Services Authorization End Date:**       | **Phone**:      **Day Program Subunit#**:       |
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| **COMPLETED BY ANCILLARY ORGANIZATIONAL PROVIDERS (IF FEE FOR SERVICE PROVIDER LEAVE BLANK)** |
| **ORGANIZATIONAL SPECIALTY MENTAL HEALTH SERVICES PROVIDER (SMHP) INFORMATION** |
|  **Legal Entity:**       **Fax**:       | **Program Name:**      **Unit#:**       | **Phone**:      **Program Subunit#**:       |
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| **TO BE COMPLETED BY ANCILLARY FEE FOR SERVICE PROVIDERS (IF ORGANIZATIONAL PROVIDER LEAVE BLANK)** |
| **FEE FOR SERVICE (FFS) SMHP INFORMATION** |
| **PROVIDER LAST NAME:**       | **PROVIDER FIRST NAME**:       | **PHONE:**       | **FAX**:       |
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| **COMPLETED BY ANCILLARY ORGANIZATIONAL OR FFS PROVIDER**  |
| **AUTHORIZATION REQUEST FOR ANCILLARY SMHS IN ADDITION TO DAY SERVICES** |
| **SELECT THE AMOUNT OF ANCILLARY SMHS REQUESTED (Inclusive of all Individual, Collateral, ICC, IHBS, Group, Rehab, Case Management or other covered SMHS provided by the Ancillary SMHP):**  |
| Sessions Requested Per Week       Ancillary Authorization Start Date:       Ancillary Provider Assignment Start Date:         | Ancillary Authorization End Date:       ***\*Matches the Day Services Authorization End Date Listed Above*** |
|  **MEDICAL NECESSITY CRITERIA FOR ANCILLARY SMHS** |
|  **Ancillary Service Necessity Criteria - check all that apply and explain (choose at least one):** [ ]  Requested service(s) is not available through the day program. Describe why service is not available:       [ ]  Continuity or transition issues make these services necessary for a time limited interval. Describe the need:       [ ]  These concurrent services are essential to coordination of care. Describe why services are essential:       |
| **Ancillary Organizational/FFS SMHP (Print):**        **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Day Service Provider (Print):**       **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    | **Credentials:**      **Date:**      **Credentials:**      **Date:**       |

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| **FOR OPTUM USE ONLY****Optum reviews and retains. Optum Authorization Determination is documented on the Prior Authorization Day Services Request (DSR) form and is viewable to the Day Service Provider and SMHP within 5 business days of Optum receipt in the CCBH Clinicians Home Page Authorizations Tab.**  |