

This form should be used to request outpatient treatment. Revised 12.01.18	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN OUTPATIENT AUTHORIZATION REQUEST Please check: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuing Request PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800)798-2254, option 3 then 3
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CONFIDENTIAL	Client Information	CONFIDENTIAL
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Client Last Name:	First:	Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	Client Ethnicity:
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Age:	DOB:	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?	Justice System Involvement: <input type="checkbox"/> N/A <input type="checkbox"/> Yes If Yes, explain: Required if "yes" above
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Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
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Current Health Plan:	If Child, current IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No School District:	San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Current Referral by Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No:	If Yes, PSW name and number: Required if "Yes"
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If Hx of CWS, when and why?

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis:	ICD 10 Code:
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Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current Symptoms (please list w/ frequency and duration):

How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis:

Hx of Trauma and/or Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain: Required if "Yes"
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Substance Use: <input type="checkbox"/> N/A <input type="checkbox"/> HX <input type="checkbox"/> Current	Drug(s) of choice: Required if "Current" or "HX"
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Describe current substance use impact on functioning:	Required if "Current " substance use
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Current Risk Assessment:	Suicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self Homicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming others
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Client Strengths (i.e., motivated, employed, strong social supports):

Medications (Psychiatric, Medical, & OTC medications)

Name of Medication w/ Dosage or N/A:

Treatment

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.):

If Group Therapy, # Participants: Group Topic/Focus:

Treatment plan with measureable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both):

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support):

How have you coordinated with these providers? If not, please explain:

Progress: N/A (Initial Request) Near completion Improving Stabilizing Regressed due to new stressor Little/no progress

Expected Length of Treatment: _____ **If Initial Request, date of Assessment with you:** _____ Required for Initial Requests

Referrals made to other community supports and/or aftercare plans for client's recovery:

Client Signature

****I, (print name) _____ participated in the development of this plan and received a copy.

Client Signature: _____ Date: _____
 (Signed Client Plan required in Client's Chart within 30 days of commencing treatment; may use separate form than the OAR)

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: Adult Child
Interpreter needed for these sessions: No Yes, Language: _____

Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
Psychotherapy (max 12)				
Group Psychotherapy (max 12, specify length of session)				
CFT Meeting (CWS only)/ Team Conference				
Conference Purpose:				
Case Management				
Case Management Purpose:				
Other:				
Other:				

Provider Information

Name/Licensure: _____ **Phone:** _____

Provider Signature: _____ **Date:** _____ **Fax:** _____

If Group Practice, name of Group: _____

If Modified or Denied,
 Date of NOA: _____

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature