This form should be used to request outpatient treatment. Revised 11.1.18	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN **OUTPATIENT AUTHORIZATION REQUEST- PSYCHIATRY** Please check: ❑ Initial Request ❑ 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

CONFIDENTIAL **Client Information** *CONFIDENTIAL*

Client Last Name: First: Middle:	Medi-Cal CIN #:	Birth Date: 00/00/0000	Current Health Plan:
If Child, current IEP: ❑ Yes ❑ No	San Diego Regional Center Client: ❑ Yes ❑ No If Yes, contact name and number:		
Current Child Welfare Services: ❑ Yes ❑ No	If Yes, PSW name and number:		
If Hx of CWS, when and why?			

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

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

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current symptoms and severity: 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? Please list symptoms with frequency and duration.

Hx of Trauma and/or Abuse? ❑ Yes ❑ No	If Yes, explain:
Substance Use: ❑ N/A ❑ Hx ❑ Current	Drug(s) of choice:
Describe current substance use impact on functioning:	

Medications (Psychiatric, Medical, & OTC medications) **Have you checked CURES: ❑ Yes ❑ No**

Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:

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:	Date of 1st Appointment/Assessment with you:

Referrals made to other community supports and/or aftercare plans for client's recovery:
(Signed client plan required in client's chart within 30 days of commencing treatment)

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
Outpatient Office Visit DO/MD/PNP only – E/M codes & therapy (max 26)				
DO/MD/PNP only – Psychotherapy Add on Code (max 26)				
Case Management				
Team Conference				

Provider Information		
Name/Licensure:	Phone:	
Provider Signature: Date:	Fax:	If Modified or Denied, Date Provider Called: _____ Date NOA sent: _____
If Group Practice, name of Group:		

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

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