

This form should be used to request outpatient treatment.
Revised 4.11.19

**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, then 4

CONFIDENTIAL **Client Information** *CONFIDENTIAL*

Client Last Name:	First:	Middle:	Medi-Cal CIN #:	Birth Date:	Current Health Plan:
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If Child, current IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No	San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, contact name and number:
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Current Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, PSW name and number:
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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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain:
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Substance Use: <input type="checkbox"/> N/A <input type="checkbox"/> Hx <input type="checkbox"/> Current	Drug(s) of choice:
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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:

1st Appointment with you was a (check one): 90792 OR 99201-99205

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 with Optum's interpreter services provider: 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