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: ☐ 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 3

CONFIDENTIAL **Client Information** ***CONFIDENTIAL***

Client Last Name:	First:	Middle:	Gender: ☐ M ☐ F ☐ O	Client Ethnicity:
Age:	DOB:	Living Situation: ☐ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐Other, with whom?		Justice System Involvement: ☐ N/A ☐ Yes If Yes, explain:

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
Current Health Plan:	If Child, current IEP: ☐ Yes ☐ No School District:	San Diego Regional Center Client: ☐ Yes ☐ No
Current Referral by 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 (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? ☐ Yes ☐ No	If Yes, explain:
Substance Use: ☐ N/A ☐ HX ☐ Current	Drug(s) of choice:
Describe current substance use impact on functioning:	

Current Risk Assessment:	Suicidal - ☐ N/A ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming self
	Homicidal - ☐ N/A ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming others

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:

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 Modified or Denied, Date of NOA: _____
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