



Outpatient Authorization Request Medication Services

To request authorization fax or mail to:
Optum Public Sector San Diego
PO Box 601370
San Diego, CA 92160-1370

Fax: (866) 220-4495 Phone: (800) 798-2254, option 3 then 4

* Indicates a required field

*SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS

Please check: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuing Request (Client seen by you within the last 6 months)			
Client Information			
*Client Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	Age:	*DOB:
*Client Ethnicity:	*Medi-Cal #:		
*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?			
San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current Employment /School Status: <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Work <input type="checkbox"/> Not in Labor Force <input type="checkbox"/> Unknown <input type="checkbox"/> Other			
*If Client under 21, current Referral by Child and Family Well-Being (CFWB) Department: <input type="checkbox"/> Yes <input type="checkbox"/> No			
*If Yes, PSW name and number:			
If History of CWS/CFWB, when and why?			
Diagnosis and Other Clinical Considerations			
*Primary DSM/ICD Diagnosis with Specifier:		*ICD Code:	
Other Diagnoses (Mental & Physical Health):			
Presenting Mental Health Problems and Symptoms			
*Current Symptoms (List the frequency and duration) that result in impairment:			
*Problem List: <input type="checkbox"/> Reviewed/updated <input type="checkbox"/> No changes		Date Problem List reviewed/updated:	
Significant Impairment			
*Distress, Disability, or Dysfunction in:		Yes	No
Social/Relational		<input type="checkbox"/>	<input type="checkbox"/>
Occupational/Academic		<input type="checkbox"/>	<input type="checkbox"/>
Other Important Activities		<input type="checkbox"/>	<input type="checkbox"/>
Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning		<input type="checkbox"/>	<input type="checkbox"/>
Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21)		<input type="checkbox"/>	<input type="checkbox"/>
*Explain Significant Impairment:			
*History of Trauma and/or Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No			
*If Yes, explain:			
*Substance Use: <input type="checkbox"/> No <input type="checkbox"/> History <input type="checkbox"/> Current		*Drug(s) of choice:	
*If current substance use, describe impact on functioning:			
Medications (Psychiatric, Medical & OTC)			
*Have you checked CURES: <input type="checkbox"/> Yes <input type="checkbox"/> No			
*Name of Medication:	*Medication Dosage & Frequency:	Name of Medication:	Medication Dosage & Frequency:
*If no medications, explain plan for medications/or need for medication monitoring:			

Provider Requested Authorization Units
Important: You must be a current contracted provider through Optum Public Sector San Diego to be able to obtain authorization for services and payment.

Interpreter needed for these sessions: No Yes, Language:

If Initial Request, First Date of Assessment:

90792 99202-99205

Treatment	*Begin Date of Sessions	*Number of Sessions	*Frequency Number of Sessions per Week/Month/Year
Outpatient Office Visit DO/MD/PA/PNP only E/M codes and therapy (max 26)			
DO/MD/PA/PNP only Psychotherapy Add on code (max 26)			
MD/DO Medical Team Conference (99367, max 1 unit per day)			
PNP/PA Medical Team Conference (99366 or 99368)			
Other:			
Targeted Case Management (T1017, 1 unit = 15 minutes)			

Targeted Case Management will focus on:

- Medical, Explain:
- Social, Explain:
- Educational, Explain:
- Other Services, Explain:

Provider Information

*Name/Licensure:

*Phone:

Fax:

*Provider Signature:

*Date:

If Group Practice, Name of Group:

Check here to waive verbal notification of authorization determination for initial requests. Written notification will be sent for all requests.

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

- Optum Reviewed OAR
- Client meets SMHS medical necessity criteria. Authorization request approved. Start Date: _____
- Initial Requests: Date of verbal notification to Provider: _____
- Provider waived verbal notification
- Name of Optum Medical Director consulted and date:* _____
- Authorization request is Denied Modified Reduced Terminated Suspended
- Date of verbal notification to Provider:* _____
- Date NOABD & Letter of Determination issued to Beneficiary and Provider:* _____
- NOABD clinical consultation summary & reason for denial:* _____

Optum Clinician Name and Date: