



# Outpatient Authorization Request Psychotherapy

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)			
<b>Client Information</b>			
*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			
Justice System Involvement: <input type="checkbox"/> N/A <input type="checkbox"/> Yes If Yes, explain:			
*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?			
<b>Diagnosis and Other Clinical Considerations</b>			
*Primary DSM/ICD Diagnosis with Specifier:	*ICD Code:		
Other Diagnoses (Mental & Physical Health):			
<b>Presenting Mental Health Problems and Symptoms</b>			
*Current Symptoms (List the frequency and duration) that result in impairment:			
*Problem List: <input type="checkbox"/> Reviewed/updated <input type="checkbox"/> No changes Date:			
<b>Significant Impairment</b>			
<b>*Distress, Disability, or Dysfunction in:</b>	<b>Yes</b>	<b>No</b>	
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:			
*Current Risk Assessment:	Suicidal: <input type="checkbox"/> No <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self		
	Homicidal: <input type="checkbox"/> No <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming others		
<b>Medications (Psychiatric, Medical &amp; OTC)</b>			
Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:
<input type="checkbox"/> No Medications			

**Interventions**

List Interventions (CBT, DBT, etc.):

Group Therapy, Number of participants:

Group Topic:

**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:**

Treatment	*Begin Date of Sessions	*Number of Sessions	*Frequency Number of Sessions per Week/Month/Year
Psychotherapy (max 1 per day, max 12 total)			
Group Psychotherapy (max 12, specify length of session)			
Other:			
Team Conference (99366 or 99368, max 1 unit per day)			
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: