This form should be used to request outpatient treatment. Revised 01.13.22	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN **OUTPATIENT AUTHORIZATION REQUEST-PSYCHIATRY** Please check: ❑ Initial Request ❑ Continuing Request **SUBMIT DEMOGRAPHIC FORM WITH EACH REQUEST**	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: 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 Description:	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? ***List symptoms with frequency and duration.***

Hx of Trauma and/or Abuse? ❑ Yes ❑ No	If Yes, explain: Required if "Yes"
Substance Use: ❑ N/A ❑ Hx ❑ Current	Drug(s) of choice: Required if "Current" or "HX"

Describe current substance use impact on functioning:
Required if "Current" substance use

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/PA/PNP only – E/M codes & therapy (max 26)				
DO/MD/PA/PNP only – Psychotherapy Add on Code (max 26)				
MD/DO Medical Team Conference (99367)				
PNP/PA Medical Team Conference (99366 or 99368)				
Other:				

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