This form should be used by FFS provider to request outpatient treatment. Revised 9.28.16	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 #5

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

Client Last Name:	First:	Middle:	Gender: ☐M ☐F ☐O	Birth Date: / /	Age:	Marital Status: ☐S ☐M ☐D ☐Sep ☐Wid
Client Address (include zip code):			Living Situation: ☐Homeless ☐Alone ☐ILF ☐B&C ☐SNF ☐Other, With whom?_____			Primary Phone:

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:	Client Ethnicity:
Current Managed Care Plan:	If Child, current IEP: ☐Yes ☐No School District:	Justice System Involvement: ☐N/A ☐Yes If Yes, explain: Required if yes above	

San Diego Regional Center Client: ☐Yes ☐No	If Yes, contact name and number:
Referred by Child Welfare Services: ☐Yes ☐No	If Yes, PSW name and number: Required if yes to the left
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

What are the current symptoms and how is the client significantly impaired in an important area of life functioning as a result of their 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: Required if yes to the left
Substance Use: ☐N/A ☐Hx ☐Current	Drug(s) of choice: Required if Hx or Current to the left
Describe current substance use impact on functioning: Required if Current use checked above	

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:

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 1st Appointment/Assessment with you: Required for Initial Requests

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: _____

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: ☐**Adult** ☐**Child**

Interpreter needed for these sessions: ☐**No** ☐**Yes, Language:** _____

CPT Code Group	Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
90834	Psychotherapy (max 12)				
90853	Group Psychotherapy (max 12, specify length of session)				
99366/ 99367	CFT Meeting (CWS only)/ Team Conference				
	Conference Purpose:				
Z5820/ Z5821	Case Management				
	Case Management Purpose:				
Other					
Other					

Provider Information

Name/Licensure: Phone:

Provider Signature: Date: Fax:

If Group Practice, name of Group:

If Initial Request, Date Called w/ Decision:

If Modified or Denied, Date of NOA:

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature