Outpatient Authorization Request
Medication Services

To request authorization fax or mail to:
Optum Public Sector San Diego
PO Box 601340
San Diego, CA 92160-1340
Fax: (866) 220-4495 Phone: (800) 798-2254, option 3 then 4

SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS

Please check: ☐ Initial Request ☐ Continuing Request (Client seen by you within the last 6 months)

Client Information

Client Name:	Gender: ☐ M ☐ F ☐ O	Age:	DOB:	Client Ethnicity:

Living Situation: ☐ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐ Other, with whom?	Medi-Cal #:

San Diego Regional Center Client: ☐ Yes ☐ No	Current Employment /School Status: ☐ Employed ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Seeking Work ☐ Not in Labor Force ☐ Unknown ☐ Other

Current Referral by Child Welfare Services: ☐ Yes ☐ No If Yes, PSW name and number:	If History of CWS, 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: ☐ Reviewed/updated; Date: _____ ***Required if "Reviewed/Updated"
☐ No changes ***Problem List: 1 Box needs to be checked; not both

Significant Impairment

Distress, Disability, or Dysfunction in:	Yes	No
Social/Relational ***At least 1 Yes Required	☐	☐
Occupational/Academic (or Yes to History of Trauma if under 21)	☐	☐
Other Important Activities	☐	☐
Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning	☐	☐
Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21)	☐	☐

Explain Significant Impairment:

History of Trauma and/or Abuse: ☐ Yes ☐ No
If Yes, explain: ***Required if "Yes"

Substance Use: ☐ No ☐ History ☐ Current Drug(s) of choice: ***Required if "History" or "Current"

If current substance use, describe impact on functioning:

Medications (Psychiatric, Medical & OTC)			
Have you checked CURES: ☐ **Yes** ☐ **No**			
Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:
If no medications, explain plan for medications/or need for medication monitoring: ***Required if no medications and dosages			

Provider Requested Authorization Units

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

If Initial Request, First Date of Assessment: ***Date Required if Initial Request

☐ 90792 ☐ 99202-99205 ***At least 1 box needs to be checked if Initial

Treatment	Begin Date of Sessions	Number of Sessions	Frequency Number of Sessions per Week/Month/Year	Optum Clinician Signature: (For Optum Care Advocate Signature – Internal Use Only)
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)				
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:
Provider Signature: Date:	Fax:
If Group Practice, Name of Group:	