Outpatient Authorization Request Psychotherapy

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			
Justice System Involvement: ☐ N/A ☐ Yes If Yes, explain:				
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: _____
☐ No changes

Significant Impairment

Distress, Disability, or Dysfunction in:	**Yes**	**No**
Social/Relational	☐	☐
Occupational/Academic	☐	☐
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:

Substance Use: ☐ No ☐ History ☐ Current Drug(s) of choice:

If current substance use, describe impact on functioning:

Current Risk Assessment:	Suicidal:	☐ No	☐ Ideation	☐ Plan	☐ Intent	☐ History of harming self
	Homicidal:	☐ No	☐ Ideation	☐ Plan	☐ Intent	☐ History of harming self

Medications (Psychiatric, Medical & OTC)

Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:

☐ No Medications

Interventions

List Interventions (CBT, DBT, etc.):

☐ Group Therapy, Number of participants: Group Topic:

Provider Requested Authorization Units

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	Optum Clinician Signature: (For Optum Care Advocate Signature – Internal Use Only)
Psychotherapy (max 12)				
Group Psychotherapy (max 12, specify length of session)				
Other:				
Team Conference (99366 or 99368)				
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:	