FAX TO: (866) 220 – 4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then option 4

THERAPEUTIC BEHAVIORAL SERVICES (TBS)
PRIOR AUTHORIZATION REQUEST & REFERRAL FORM

☐ Initial Request (submitted by SMHP) ☐ Continuing Request (6 mos.) (Submitted by TBS provider)

* Indicates a required section for Initial Requests

Youth Information*:

*Name: _____	*DOB: _____	*Medi-Cal or SSN: _____
*Current Address: _____		
School: _____	School District: _____	
*Parent/Caregiver Name: _____	*Parent/Caregiver Phone: _____	

Referring Party/Therapist Information*: ***Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.***

*SMHP Name: _____	*SMHP Credential: _____
*SMHP Program Name: _____	*Address: _____
*Phone: _____	*Fax: _____

Additional Referring Party Information: (*If same as SMHP, please leave blank)*

Name: _____	Agency: _____	Relationship: _____
Address: _____		
Phone: _____	Fax: _____	E-Mail: _____

CWS/Probation Involved: ☐ Yes ☐ No CWS Contact Name: _____ Probation Contact Name: _____

Phone: _____	Fax: _____	E-Mail: _____

Other Party Involvement: *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

Name/Relationship: _____	Contact Phone: _____
Name/Relationship: _____	Contact Phone: _____

Specific requests with regard to TBS Coach's language, culture, gender, etc.: _____

TBS Class Criteria / Eligibility (Completed by SMHP)* – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21? ☐ **Yes** ☐ **No** **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager? ☐ **Yes** ☐ **No**
3. Which of the following conditions have been met by the Youth? *(*Check all that apply, must check a minimum of 1)*
   - ☐ Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months
   - ☐ Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs
   - ☐ Youth may need out of home placement, a higher level of residential or acute care
   - ☐ Youth is transitioning to a lower level of care and needs TBS to support the transition
   - ☐ Youth has previously received TBS while a member of the certified class
   - ☐ Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

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Medical Necessity Criteria, completed by the SMHP*:

1. ***Diagnosis for focus of TBS**: _____
2. ***Client demonstrates impairment as a result of the included diagnosis** (*at least one of the following applies*):
   - ☐ significant impairment in an important area of life functioning
     e.g., living situation, daily activities, or social support

     OR
   - ☐ a reasonable probability of significant deterioration in an important area of life functioning

     OR
   - ☐ a reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate
3. ***Client meets each of the intervention criteria listed below:**
   - A. ☐ The focus of the TBS intervention will address the condition/impairment
   - B. Expectation that TBS will:
     - ☐ Significantly diminish the impairment **OR**
     - ☐ Prevent significant deterioration in an important area of life functioning **OR**
     - ☐ Allow the child to progress developmentally as individually appropriate
   - C. ☐ The condition would not be responsive to physical health care-based treatment
4. ***Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or Progress Note that demonstrates the above criteria** Click to enter a date.
5. *SMHP Clinician is requesting the following TBS services: ***(Must include amount, scope & duration)***
   - ☐ Up to 25 hours of TBS Intervention per week - **amount**
   - ☐ TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)
   - ☐ Up to 6 months of TBS Intervention – **duration**
   - ☐ Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*:
     _____

SMHP submitted form to Optum on*: Click to enter a date.
(Optum shall notify provider of determination within 5 business days of receipt)

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, OAR or Progress Note**

☐ **TBS scope, amount and duration authorized as requested: START DATE**: _____ **END DATE**: _____

☐ **Additional TBS hours authorized per week** (beyond 25 hours per week): _____

TBS Request is Reduced/Modified as follows: ☐scope _____ **☐amount** _____ **☐duration** _____

TBS request is ☐denied ☐modified ☐reduced ☐terminated or ☐suspended

NOABD was issued to the beneficiary and provider on the following date: _____

☐ Optum unable to confirm SMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

Optum Clinician Signature/Date/Licensure:

Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider

^Date pre-authorization received by TBS Provider: _____ (^*completed by New Alternatives)*

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO