



San Mateo County Managed Care Continued Authorization Request

Complete and submit prior to expiration of initial authorization. Submitting at least two weeks in advance will prevent any gaps in service as all services must be preauthorized.

CLIENT NAME	DOB	MH#			
PROVIDER NAME		DATE OF REQUEST			
PROVIDER TELEPHONE CURRENT FUNCTIONING (CHECK ALL			-		
□ Current □ Recent decrease in functioning or	n a life area due f	to primary diagnosis			
Current difficulty maintaining employment/sc	hooling/living sit	uation due to mental health symptoms*			
On-going mental health symptoms related to	primary diagnos	sis needing treatment			
$\hfill\square$ Current $\hfill\square$ Recent risk -of harm to others (thr	eats, significant	ideations, violent acts)*			
□ Current □ Recent risk -of harm to self (threats, significant ideations, attempts, plans)*					
□ Current □ Recent risk -hallucinations, bizarre	e behavior, or de	lusional thoughts*			
\Box Current \Box Recent risk- gravely disabled (una	able to perform m	nost daily tasks)*			
Current Recent risk- Health is at significant risk due to mental health symptoms*					

□ Current □ Recent Psychiatric hospitalization within the last 6 months*

* Note: Checking any of the above risk factors may indicate the need for higher level of care. If so determined, please contact Call Center staff at 1-800-686-0101.

CLINICAL UPDATE SINCE INITIAL ASSESSMENT DATED: _

Include symptoms, behaviors and functional impairments: including above checked risk factors

MENTAL HEALTH DIAGNOSIS: based on client's presentation at the time of assessment; focus of clinical attention or treatment

DSM 5	ICD-10 Code	
		PRINCIPAL DX
		SECONDARY DX

PROVIDER SIGNATURE ______ LICENSE NO._____ DATE_____

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."



MANAGED CARE CONTINUED AUTHORIZATION REQUEST

Confidential Patient Information: See California Welfare and Institutions Code Section 5328				
CLIENT NAME	MH#	DOB		
PROVIDER NAME	PROVIDER TELEPH	ONE #		
CLIENT	PLAN END DAT	eeks in advance will prevent any gaps in E (1 yr.max)		
DIAGNOSIS/PROBLEMS/IMPAIRMI the diagnosis that impede client fror must be addressed in all medical ne	m achieving desired outcome. Impa		om	
	ehaviors and reduction, stabilizatio	n, or removal of		
GOAL - Development of new skills/be symptoms/impairments. OBJECTIVES - Client's next steps to objectives that address symptoms/ir	achieving goal. Must be observa	ble, measurable and time-limite	ed	
symptoms/impairments.	achieving goal. Must be observa mpairments linked to the primary il the interventions proposed for <u>ea</u> ician will provide individual therapy	ble, measurable and time-limite diagnosis. ach service type: Individual Thera		
symptoms/impairments. OBJECTIVES - Client's next steps to objectives that address symptoms/ir INTERVENTIONS – Describe in deta Medication Supportetc. (E.g. – Clin	achieving goal. Must be observa mpairments linked to the primary il the interventions proposed for <u>ea</u> ician will provide individual therapy	ble, measurable and time-limite diagnosis. ach service type: Individual Thera		
Symptoms/impairments. OBJECTIVES - Client's next steps to objectives that address symptoms/in INTERVENTIONS – Describe in deta Medication Supportetc. (E.g. – Clin techniques, to assist client with decre	achieving goal. Must be observa npairments linked to the primary il the interventions proposed for <u>ea</u> ician will provide individual therap	ble, measurable and time-limite diagnosis. <u>ach service type</u> : Individual Thera y, utilizing cognitive-behavioral		
Symptoms/impairments. OBJECTIVES - Client's next steps to objectives that address symptoms/in INTERVENTIONS – Describe in deta Medication Supportetc. (E.g. – Clin	achieving goal. Must be observa mpairments linked to the primary il the interventions proposed for <u>ea</u> ician will provide individual therap easing his depressive symptoms.)	ble, measurable and time-limite diagnosis. <u>ach service type</u> : Individual Thera y, utilizing cognitive-behavioral Date		

Fax to 650-596-8065 or mail to Access Call Center – 310 Harbor Blvd., Bldg. E, Belmont, CA 94002



MANAGED CARE CONTINUED AUTHORIZATION REQUEST

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CLIENT NAME_____

MH#_____DOB

PROVIDER NAME______PROVIDER TELEPHONE #_____

TREATMENT AUTHORIZATION REQUEST

CPT Code	Bilingual Differential Yes/No	Number of Services	Frequency	Authorization Begin Date