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

COUNTY OF SAN MATEO
HEALTH SYSTEM

MD/NP Behavioral Health Outpatient Assessment, Client Plan & Authorization Request

Fax or mail completed form to:

BHRS ACCESS Team, 310 Harbor Blvd. Belmont, CA 94402

Phone: 1-800-686-0101 **Fax: (650) 596-8065**

DIRECTIONS – Submit after initial authorization for assessment or if on-going treatment is being requested, prior to expiration of initial authorization. Incomplete information may result in delay of authorization for services. **Please complete all information requested on this form. Any services provided without prior authorization will be denied.**

PROVIDER (Print)_____ Phone_____ Fax_____

CLIENT NAME_____ DOB_____ Date_____

Current Clinical Issues

Substance Abuse ☐ Current ☐ Past ☐ None Describe type, amount, frequency (incl Nicotine, Caffiene, and OTC)

History, Relevant Clinical or Other Information (Include present &/or previous physical &/or sexual abuse – victim &/or perpetrator)

Medications (for Medical and Psychiatric Conditions)

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PROVIDER (Print)_____CLIENT NAME_____

Diagnosis Use **"P"** and **"S"** to specify one **Primary** and one **Secondary** Mental Health Diagnosis. You may report up to three additional diagnoses. Do not enter the Code for a "Rule Out" Diagnosis.

DSM5 Diagnosis	ICD-10	P/S	DSM5 Diagnosis	ICD-10	P/S

General Medical Conditions:

Other Factors Significantly Affecting Mental Health

Substance Abuse	☐	Yes	☐	No	☐	Unknown
Developmental Disabilities	☐	Yes	☐	No	☐	Unknown
Physical Health Disorders	☐	Yes	☐	No	☐	Unknown

Treatment Goals

1)_____Target Date_____

2)_____Target Date_____

These goals have been formulated in conference with, and have the approval of, the Mental Health Plan member/parent or guardian.

Provider Signature_____Date_____

Client/Parent _____Date_____

TREATMENT AUTHORIZATION REQUEST

CPT CODE	Bilingual Differential Yes/No	# of sessions Requested	Frequency	Authorization Begin Date