[Physician/Clinician Name]
[Facility/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attention: Medical Review/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Psychiatric Residential Treatment

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request authorization for [Patient Name] to be admitted to a Psychiatric Residential Treatment Center (RTC). As the patient's treating [Physician/Psychiatrist/Clinician], I have determined that this level of care is medically necessary due to the severity and persistence of the patient's psychiatric symptoms.

Current Diagnosis:
[List ICD-10 Codes and Diagnostic Names]

Clinical Summary:
[Describe patient's current symptoms, behavioral issues, and safety risks to self or others. Detail why current functioning is impaired.]

Treatment History and Failures:
[Patient Name] has attempted less intensive levels of care without sufficient stabilization, including:

- [List Outpatient Therapy/Psychiatry dates and results]
- [List Intensive Outpatient (IOP) or Partial Hospitalization (PHP) dates and results]
- [List Acute Inpatient Hospitalizations, if applicable]

Necessity for Residential Care:
The patient requires a 24-hour structured therapeutic environment because [Reason: e.g., inability to maintain safety at home, need for medication titration under constant supervision, or failure of community-based interventions]. Treatment at a lower level of care is currently unsafe and clinically inappropriate.

Treatment Plan:
During residential treatment, the patient will receive [List services: e.g., individual therapy, group therapy, family therapy, and medication management] with the goal of [State specific goals for discharge].

Based on the patient's clinical presentation, it is my professional opinion that Psychiatric Residential Treatment is the most appropriate and medically necessary setting for [Patient Name].

Please contact me at [Phone Number] if you require further documentation or clinical records.

Sincerely,

[Signature]
[Printed Name and Credentials]
[NPI Number]