Date: [Date]

To: [Insurance Company Name / Utilization Review Department]
Attention: [Case Manager Name, if known]
Fax/Address: [Fax Number or Mailing Address]

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 recommend and request authorization for **Psychiatric Residential Treatment (RTC)** for [Patient Name]. As the patient's [Current Provider Title/Role], I have determined that this level of care is medically necessary due to the severity of their symptoms and the failure of lower levels of care to maintain safety and stabilization.

Clinical Diagnoses:
[List ICD-10 Codes and Diagnosis Names]

Clinical Presentation and Current Symptoms:
[Patient Name] is currently experiencing acute symptoms including:

- [Symptom 1: e.g., Suicidal ideation with plan/intent]
- [Symptom 2: e.g., Self-injurious behaviors]
- [Symptom 3: e.g., Severe emotional dysregulation or aggression]
- [Symptom 4: e.g., Inability to perform activities of daily living]

Previous Treatment History:
The patient has attempted the following interventions without sustained success:

- [Previous Treatment 1: e.g., Outpatient therapy - Dates/Frequency]
- [Previous Treatment 2: e.g., Intensive Outpatient (IOP) or Partial Hospitalization (PHP)]
- [Previous Treatment 3: e.g., Recent Acute Inpatient Psychiatric Admissions]

Reason for Residential Level of Care:
Outpatient and community-based services are no longer sufficient to ensure the patient's safety. The patient requires 24-hour nursing supervision, a structured therapeutic environment, and daily clinical intervention to address [Primary Clinical Issue]. Without this level of care, the patient is at high risk for [Specific Risk: e.g., re-hospitalization, self-harm, or further clinical decline].

Treatment Goals:
The goals for this residential placement include:

- [Goal 1: e.g., Medication stabilization and management]
- [Goal 2: e.g., Development of crisis coping mechanisms]
- [Goal 3: e.g., Behavioral stabilization to allow return to home/community]

I strongly urge you to approve this request for Psychiatric Residential Treatment. Please contact me at [Phone Number] if you require further clinical documentation or a peer-to-peer review.

Sincerely,

[Physician/Provider Signature]
[Printed Name and Credentials]
[NPI Number]
[Facility/Clinic Name]