[Date]

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

RE: Letter of Medical Necessity for Psychiatric Residential Treatment
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request authorization for residential psychiatric treatment for my patient, [Patient Name]. Based on my clinical evaluation and the patient's history, I have determined that this level of care is medically necessary.

Clinical Diagnosis:
[List ICD-10 Codes and Diagnosis Descriptions]

Clinical Summary and Symptoms:
[Patient Name] presents with [list primary symptoms, e.g., severe depression, suicidal ideation, self-harm, inability to function at school/home]. Despite previous interventions, the patient continues to experience [list specific behaviors or acute risks].

Treatment History:
The patient has attempted the following lower levels of care without success:
- [List previous outpatient therapy, dates, and results]
- [List medication trials and outcomes]
- [List Intensive Outpatient (IOP) or Partial Hospitalization (PHP) programs if applicable]

Rationale for Residential Level of Care:
The patient requires 24-hour supervision and a structured therapeutic environment because [state reason, e.g., safety risk to self/others, failure to maintain stability in a community setting]. Residential treatment is necessary to provide [list specific goals, e.g., medication stabilization, intensive behavioral therapy, safety monitoring].

In my professional opinion, treatment in a less restrictive environment is currently insufficient to manage the patient's condition. Failure to provide this level of care may result in [list risks, e.g., acute psychiatric crisis, emergency hospitalization].

Please contact my office at [Phone Number] if you require additional documentation or a peer-to-peer review.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number/NPI]
[Practice Name]