

**Date:** [Date]

**TO:** [Insurance Company Name/Review Board]

**ATTN:** [Case Manager/Utilization Review Department]

**FAX/ADDRESS:** [Fax Number or Mailing Address]

**RE:** [Patient Full Name]

**DOB:** [Patient Date of Birth]

**Member ID:** [Insurance ID Number]

**Policy Group:** [Group Number]

**Subject: Letter of Medical Necessity for Admission to Psychiatric Residential Treatment (Level of Care: ASAM/LOCADTR equivalent)**

To Whom It May Concern,

I am writing to formally request authorization for the admission of [Patient Name] to a Psychiatric Residential Treatment Center (RTC). As the patient's [Current Provider Title, e.g., Treating Psychiatrist], I have determined that this level of care is medically necessary due to the patient's clinical instability and the failure of less restrictive treatment environments.

### **I. Clinical Diagnoses (ICD-10):**

- Primary: [Diagnosis Name and Code]
- Secondary: [Diagnosis Name and Code]
- Other: [Co-occurring disorders, e.g., Substance Use or Medical Conditions]

### **II. Current Clinical Presentation and Symptoms:**

[Detail specific symptoms: e.g., suicidal ideation with plan/intent, self-injurious behavior, psychosis, severe emotional dysregulation, inability to perform activities of daily living, or aggressive behaviors.]

### **III. Treatment History and Failure of Lower Levels of Care:**

The patient has attempted the following interventions without sustained stabilization:

- [Date]: Outpatient Therapy/Psychiatry (Frequency: [X] times per week) - Result: [Explain why insufficient]
- [Date]: Intensive Outpatient Program (IOP) - Result: [Explain why insufficient]
- [Date]: Partial Hospitalization Program (PHP) - Result: [Explain why insufficient]
- [Date]: Acute Inpatient Hospitalization - Result: [Explain why symptoms recurred upon discharge]

### **IV. Risk Assessment and Functional Impairment:**

[Describe the immediate risks to the patient or others. Detail how the patient's psychiatric condition has led to a functional collapse at school, home, or work.]

#### **V. Rationale for Residential Treatment:**

The patient requires 24-hour supervision and a structured therapeutic environment to ensure safety and to implement intensive clinical interventions. Specifically, the patient requires:

- 24/7 Monitoring to prevent [Self-harm/Escape/Impulsive acts].
- Daily therapeutic oversight and medication management.
- A controlled environment to develop coping skills that have failed in community settings.

#### **VI. Proposed Treatment Plan and Discharge Goals:**

The goal of residential treatment is to achieve [Goal 1: e.g., stabilization of mood], [Goal 2: e.g., elimination of self-harming behaviors], and [Goal 3: e.g., medication titration] so the patient can safely return to a [PHP/IOP/Outpatient] level of care.

#### **Conclusion:**

Without this level of care, the patient is at high risk for [further decompensation/acute hospitalization/death]. Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Signature]

[Printed Name and Credentials]

[Facility/Practice Name]

[NPI Number]