URGENT: EXPEDITED REVIEW REQUESTED

Date: [Insert Date]

To: [Insurance Company Name / Utilization Review Department]

Attention: Medical Director

Fax Number: [Insert Fax Number]

Re: Letter of Medical Necessity for Psychiatric Residential Treatment Center (RTC)

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]
Requested Facility: [Insert Facility Name]

To Whom It May Concern,

I am writing to formally request immediate authorization for admission to a Psychiatric Residential Treatment Center (RTC) for [Patient Name]. As [Patient Name]'s treating physician/clinician, I have determined that this level of care is medically necessary due to the severity of their psychiatric condition and the failure of less intensive interventions.

Clinical Diagnoses:
1. [Diagnosis Name] ([ICD-10 Code])
2. [Diagnosis Name] ([ICD-10 Code])

Current Clinical Status and Risk Factors:
The patient is currently experiencing [Describe acute symptoms: e.g., suicidal ideation, self-harm behaviors, psychosis, or extreme emotional dysregulation]. [Patient Name] currently presents a significant risk to [self/others] and requires 24-hour clinical supervision and stabilization that cannot be safely provided in an outpatient or partial hospitalization setting.

Previous Treatment History:
The patient has attempted the following levels of care without sustained stabilization:
- [Treatment Type/Date]: [Result/Reason for failure]
- [Treatment Type/Date]: [Result/Reason for failure]

Medical Necessity Justification:
Residential treatment is required to provide [Insert specific needs: e.g., intensive medication management, 24/7 safety monitoring, trauma-informed therapy]. Without this intervention, the patient is at high risk for [Insert risk: e.g., acute hospitalization, permanent disability, or death]. This request meets the criteria for medical necessity as the patient's condition is complex, chronic, and requires a structured environment for therapeutic progress.

Please expedite this review due to the urgent nature of the patient's psychiatric instability. I am available for a peer-to-peer review at [Insert Phone Number] if further clarification is required.

Sincerely,

[Your Signature]
[Your Printed Name and Credentials]
[Facility/Practice Name]
[Phone Number]