[Physician/Provider Letterhead]

[Date]

[Insurance Company Name]
[Attn: 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]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request authorization for admission to a Psychiatric Residential Treatment Center (RTC). I have been treating [Patient Name] since [Date] for [Diagnosis/Condition].

Clinical Diagnosis:
[Insert ICD-10 Codes and Diagnosis Names]

Current Clinical Presentation:
[Patient Name] is currently experiencing severe symptoms, including [List symptoms: e.g., suicidal ideation, self-harm, aggression, inability to perform activities of daily living]. Despite ongoing interventions, the patient remains a risk to [self/others] and requires 24-hour clinical supervision and a structured therapeutic environment.

Treatment History and Failures:
Lower levels of care have been utilized without sufficient stabilization, including:

- [Level of Care: e.g., Intensive Outpatient] from [Date] to [Date]. Outcome: [Reason for failure].
- [Level of Care: e.g., Partial Hospitalization] from [Date] to [Date]. Outcome: [Reason for failure].
- [Medication Trials: List medications and results].

Medical Necessity Justification:
Psychiatric Residential Treatment is medically necessary at this time because the patient requires a secure setting to address [Specific behavioral/psychological goals]. The patient's condition is of such severity that outpatient or community-based services are insufficient to ensure safety and provide the intensity of treatment required for recovery.

Proposed Treatment Plan:
At the RTC level of care, [Patient Name] will receive [Specific therapies, e.g., CBT, DBT, trauma-informed care, medication management]. The expected goal of this treatment is [Expected outcome, e.g., stabilization of mood, reduction of self-harming behaviors, reintegration into the community].

I strongly recommend that [Patient Name] be approved for Residential Treatment to prevent further clinical deterioration. Please contact me at [Phone Number] or [Email] if you require further documentation.

Sincerely,

[Signature]
[Printed Name and Credentials]
[NPI Number]
[Facility/Practice Name]