[Date]

[Insurance Company Name]
[Attn: Utilization 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: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing as the Medical Director for [Facility Name/Practice] to formally document the medical necessity for [Patient Name]'s admission to a Psychiatric Residential Treatment Center (RTC). Based on my clinical evaluation and a review of the patient's medical history, it is my professional opinion that residential care is the most appropriate and least restrictive level of care required to ensure the safety and stabilization of this patient.

Clinical Diagnoses:

- [Primary Diagnosis Code and Description]
- [Secondary Diagnosis Code and Description]
- [Additional Relevant Diagnoses]

Clinical Presentation and Current Symptoms:
[Patient Name] is currently presenting with severe symptoms including [list symptoms, e.g., suicidal ideation, self-harm, psychosis, treatment-resistant depression]. These symptoms have resulted in significant functional impairment in [school/work/home life].

Failure of Lower Levels of Care:
Despite active participation, the patient has not stabilized in the following settings:

- [List previous treatments, e.g., Intensive Outpatient (IOP), Partial Hospitalization (PHP), or Weekly Therapy]
- [Specific dates and outcomes of previous interventions]

Necessity for 24-Hour Supervision:
At this time, the patient requires a structured, therapeutic environment with 24-hour nursing and psychiatric supervision because [reason, e.g., inability to maintain safety at home, high risk of relapse, or medical instability]. Treatment in a residential setting is necessary to implement [specific interventions, e.g., medication titration, intensive trauma therapy, behavioral modification].

Treatment Goals:
The expected duration of stay is [estimated timeframe]. The goals for this admission include [list goals, e.g., stabilization of mood, development of coping skills, reduction of self-harming behaviors] with the ultimate objective of transitioning the patient back to a community-based level of care.

I request that you authorize coverage for this medically necessary treatment. If you require further clinical documentation or wish to schedule a Peer-to-Peer review, please contact my office at [Phone Number].

Sincerely,

[Signature]
[Medical Director Name, MD/DO]
[Medical License Number]
[Facility Name]