[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 Name]
Date of Birth: [DOB]
Member ID Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request authorization for [Patient Name] to receive care at a Psychiatric Residential Treatment Center (RTC). As the patient's [Treating Physician/Psychiatrist/Therapist], I have determined that this level of care is medically necessary due to the severity and persistence of their psychiatric symptoms.

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

Clinical Summary and Current Symptoms:
[Provide a brief history of the patient's condition. Describe current symptoms such as self-harm, suicidal ideation, aggression, inability to perform daily functions, or severe emotional dysregulation.]

Treatment History and Failure of Lower Levels of Care:
The patient has attempted the following interventions without sufficient improvement:
- [Outpatient Therapy/Medication Management: Dates/Results]
- [Intensive Outpatient Program (IOP): Dates/Results]
- [Partial Hospitalization Program (PHP): Dates/Results]
- [Acute Inpatient Hospitalization: Dates/Results]

Rationale for Residential Treatment:
The patient requires a 24-hour therapeutic environment with structured supervision because [Reason: e.g., high risk of relapse, safety concerns in the home, or need for intensive medication titration]. At this time, the patient cannot be safely or effectively treated at a less restrictive level of care.

Proposed Treatment Plan:
While in residential treatment, the patient will receive [Describe services: e.g., individual therapy, group therapy, family therapy, and psychiatric monitoring] with the goal of stabilizing symptoms and developing coping mechanisms for a successful return to the community.

I request that you approve coverage for this medically necessary treatment. Please contact me at [Phone Number] or [Email Address] if you require further clinical documentation.

Sincerely,

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