

Date: [Insert Date]

TO: [Insurance Company Name]

ATTN: [Appeals/Utilization Management Department]

FAX: [Insert Fax Number]

RE: [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance ID Number]

Reference Number: [Prior Auth Number if applicable]

Dear Medical Reviewer,

I am writing to formally request authorization for **Psychiatric Residential Treatment Facility (PRTF)** placement for [Patient Name]. I have been treating this patient since [Date] for the following diagnoses: [List ICD-10 Codes and Diagnoses].

Clinical Presentation and Severity:

[Patient Name] is currently experiencing acute psychiatric symptoms that cannot be safely or effectively managed in a lower level of care. Current symptoms include: [e.g., suicidal ideation, self-harm, aggression, psychosis, or severe functional impairment].

Failure of Lower Levels of Care:

The patient has attempted and failed the following interventions:

- [List failed treatments: e.g., Outpatient therapy, Intensive Outpatient (IOP), Partial Hospitalization (PHP)]

- [List previous acute inpatient stays and dates]

These interventions were unsuccessful because: [Briefly explain why lower levels failed].

Necessity for Residential Care:

At this time, [Patient Name] requires 24-hour medical supervision, a structured therapeutic environment, and intensive medication management to ensure safety and stabilize their condition. Without PRTF intervention, there is a high risk of [e.g., further stabilization failure, harm to self/others, or permanent functional decline].

Treatment Plan:

The goal of this admission is to [List goals: e.g., stabilize mood, implement behavior modification, titrate medications]. We anticipate a length of stay of approximately [Number] days, with a discharge plan focused on returning to [Community/Home] with [Support Services].

In my professional medical opinion, PRTF placement is the most appropriate and medically necessary level of care for this patient. Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name and Credentials]

[Facility/Practice Name]

[NPI Number]