

[Date]
[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of Psychiatric Therapy

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to provide a formal letter of medical necessity for the continued psychiatric therapy of my patient, [Patient Name]. [Patient Name] has been under my care since [Start Date] for the treatment of [Diagnosis Name(s)] (ICD-10 Code: [Code]).

Current Clinical Status:

The patient is currently exhibiting symptoms including [List symptoms, e.g., severe anxiety, depressive episodes, suicidal ideation, etc.]. While progress has been made in areas such as [List improvements], the patient remains at high risk for [List risks, e.g., relapse, hospitalization, functional impairment] if treatment is interrupted at this time.

Treatment Plan:

The current treatment plan consists of [Frequency, e.g., once weekly] psychotherapy sessions. The goals for continued care include:

1. [Goal 1]
2. [Goal 2]
3. [Goal 3]

Medical Necessity:

Continued therapy is medically necessary to maintain the patient's current stability and to prevent a decline in their mental health status. At this stage, the patient has not yet reached maximum therapeutic benefit. Discontinuation of services would likely lead to a recurrence of acute symptoms and may necessitate more intensive and costly levels of care, such as partial hospitalization or inpatient psychiatric admission.

I am requesting authorization for [Number] additional sessions over the next [Number] months. Please contact my office at [Phone Number] or [Email Address] if you require further clinical documentation or have questions regarding this request.

Sincerely,

[Provider Signature]
[Provider Name, Credentials]

[Provider NPI Number]
[Practice Name]