Date: [Date]

RE: Documentation of Failed Outpatient Treatments
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy/ID Number: [ID Number]

To Whom It May Concern,

This letter serves to document the outpatient treatment interventions attempted for [Patient Name] regarding the diagnosis of [Diagnosis/Condition]. Despite consistent adherence to the following prescribed treatments, the patient has not achieved significant clinical improvement.

Summary of Previous Treatments:

- **Treatment/Medication:** [Name of Treatment]
  Duration: [Start Date] to [End Date]
  Outcome: [e.g., Inadequate symptom relief, adverse side effects, or disease progression]
- **Treatment/Medication:** [Name of Treatment]
  Duration: [Start Date] to [End Date]
  Outcome: [e.g., Minimal response, intolerable toxicity, or contraindication]
- **Therapy/Procedure:** [e.g., Physical Therapy, CBT, etc.]
  Frequency/Duration: [Details]
  Outcome: [e.g., Functional status remained unchanged or declined]

Clinical Justification:

Based on the failure of the above conservative and outpatient measures, the patient's current symptoms including [List Key Symptoms] continue to impact their daily functioning. Therefore, it is medically necessary to escalate treatment to [Name of Requested Treatment/Higher Level of Care].

Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Facility/Clinic Name]
[NPI Number]