[Date]

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

**RE: Letter of Medical Necessity for Partial Hospitalization Program (PHP)**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [DOB]
**Member ID:** [ID Number]
**Provider/Facility:** [Facility Name]

To Whom It May Concern,

I am writing to formally justify the medical necessity for [Patient Name] to be admitted to a Psychiatric Partial Hospitalization Program (PHP). Based on my recent clinical evaluation, the patient requires a structured, multi-disciplinary level of care that exceeds the capabilities of traditional outpatient therapy.

**Clinical Presentation and Diagnosis:**
The patient meets the criteria for [Primary Diagnosis/ICD-10 Code]. Current symptoms include:

- [Symptom 1: e.g., Severe depressive episodes]
- [Symptom 2: e.g., Acute anxiety interfering with daily functioning]
- [Symptom 3: e.g., Passive suicidal ideation without immediate plan]

**Justification for PHP Level of Care:**
The patient is currently experiencing a significant decline in global functioning. PHP is necessary because:

- The patient requires daily medical monitoring and medication management.
- Traditional outpatient treatment (once weekly) has proven insufficient to stabilize the patient's condition.
- The patient is at high risk for inpatient psychiatric hospitalization if this intensive intervention is not provided.
- The patient possesses a stable living environment to return to at night but lacks the coping mechanisms to remain safe or functional during the day without professional oversight.

**Treatment Plan:**
While in PHP, the patient will receive [Number] hours of therapy per day, including individual counseling, group therapy, and psychiatric medication titration. The goal of this treatment is to [Goal: e.g., stabilize mood, reduce self-harm risk, and transition to intensive outpatient care].

In summary, the Partial Hospitalization Program is the least restrictive environment that can safely and effectively treat the patient's current psychiatric acuity. Please contact me at [Phone Number] if further information is required.

Sincerely,

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