Date: [Date]

Patient Name: [Patient First and Last Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

To: [Insurance Company Name / Referring Physician]

Subject: Proposed Partial Hospitalization Program (PHP) Treatment Plan

Clinical Diagnosis:

- Primary: [Diagnosis Code and Description]
- Secondary: [Diagnosis Code and Description]

Treatment Setting and Duration:

The patient is recommended for a Partial Hospitalization Program (PHP) to meet 5 days per week, approximately 6 hours per day. The estimated duration of treatment is [Number] weeks, pending regular clinical review.

Clinical Justification:

[Briefly describe the symptoms or behaviors that require a higher level of care than standard outpatient therapy, such as inability to function in daily life, safety risks, or failure of lower levels of care.]

Treatment Goals:

1. [Goal 1: e.g., Stabilization of acute depressive symptoms]
2. [Goal 2: e.g., Development of healthy coping mechanisms for crisis management]
3. [Goal 3: e.g., Medication titration and monitoring]

Interventions and Services:

- Group Therapy (CBT/DBT modalities)
- Individual Psychotherapy
- Psychiatric Medication Management
- Family Therapy/Support Sessions
- Nursing Assessments

Discharge Criteria:

The patient will be considered for step-down to Intensive Outpatient (IOP) or standard outpatient care when: [Describe specific markers of improvement, e.g., patient is no longer a risk to self and can manage symptoms independently for 48 hours].

Sincerely,

[Signature]

[Provider Name, Title]
[Facility Name]
[Phone Number]
[Email Address]