Date: [Date]

To: [Insurance Company Name]
Attention: Appeals/Medical Review Department
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Psychiatric Evaluation

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request authorization and state the medical necessity for a comprehensive outpatient psychiatric evaluation for the above-named patient.

Clinical Justification:
The patient is currently presenting with symptoms including [list symptoms, e.g., severe anxiety, persistent depression, sleep disturbances, or cognitive decline]. These symptoms have resulted in significant functional impairment in the patient's [work/school/social] life.

Purpose of Evaluation:
This evaluation is required to:
- Establish a definitive differential diagnosis.
- Determine the need for psychotropic medication management.
- Develop an appropriate long-term treatment plan to prevent clinical worsening or hospitalization.

Diagnosis/ICD-10 Codes: [Insert Codes, e.g., F32.9]

Based on the patient's clinical presentation, it is my professional opinion that this evaluation is medically necessary and is the most appropriate next step in their care. Failure to provide this evaluation may result in an escalation of symptoms and a higher level of care in the future.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician/Provider Signature]
[Provider Name and Credentials]
[NPI Number]
[Facility/Clinic Name]