State of Connecticut
Department of Mental Health and Addiction Services

Behavioral Health Recovery Program (BHRP)

Appeal Request and Disposition Form for Basic Recovery Supports

Please fax this form to:
Advanced Behavioral Health, Inc
Fax # 1-866-249-8766

Name of applicant requesting appeal / reconsideration: ______________________________

Phone #: ______________________ Encounter #: ______________________

Current address: ____

Treatment program: ______________________ Program phone #: ______________

Name of treatment staff: ______________________ Program fax #: ______________

If all or part of your application is denied, you can request an appeal of the decision with the help of your treatment provider or anyone else you choose. If you would like your request to be reconsidered, your first-level appeal must be received within 7 calendar days of the denial of the requested supports. Please state why you feel the decision should be reconsidered. You are welcome to continue on the back of this form or submit any additional supporting documentation:

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Applicant's Signature: ______________________ Date: ______________

Preparer's Signature: ______________________ Date: ______________

Appeal Request Disposition completed by ABH, Inc.

Outcome: Upheld Reversed

Date Received _____/____/______ Decision Date:____/____/______ Effective Date ____/____/____

Service Type: __________________________ Amount:____________________Rationale:___________________

Narrative:____

You can appeal this decision through a second-level appeal. The second-level appeal must be filed with DMHAS no later than seven (7) calendar days after the first level appeal decision. All second-level appeals correspondence should be directed to:

Department of Mental Health & Addiction Services
Managed Services Division
Fax; 860-418-6730

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