

COVID-19 BEHAVIORAL HEALTH ASSISTANCE PROGRAM
Department of Mental Health & Addiction Services
VOUCHER REQUEST FORM

Thank you for your interest in the DMHAS COVID-19 Behavioral Health Assistance Program administered by Advanced Behavioral Health, Inc. The Program provides vouchers to eligible employees at DMHAS agencies who are seeking outpatient behavioral health therapy. The funds are available to assist individuals in satisfying co-payments or insurance deductibles related to their outpatient behavioral health therapy.

- Please fill out the attached form. You will need to complete all of Section I of the Voucher Request Form and your therapist will need to complete Section 2 of the form. The information requested on the form is based on data elements required by the Federal agency providing funding for this grant, the Substance Abuse and Mental Health Services Administration (SAMHSA). Individually-identifiable Information collected on the form is confidential and will not be shared with DMHAS or any other party.
- You will need to include a copy of the Explanation of Benefits (EOB) document you receive from your insurance company when submitting the Voucher Request. This form contains information that will assist ABH in determining the amount of your voucher payment. This document details the service date, amount billed, and the amount of patient responsibility.
- The Voucher Request Form (Sections 1 and 2) and EOB document should be submitted together. You may submit the documents via fax or U.S. mail. **Faxed requests should be sent to: (860) 704-6145. Mailed requests should be sent to: Advanced Behavioral Health, Inc., ATT: COVID-19 BHAP, 213 Court Street, Middletown, CT 06457.**
- The Voucher Request Form can be completed either by hand or electronically, except for the signatures of the individual in treatment and the treatment provider. To populate checkboxes on the form if completing it electronically, place the cursor over the check box and click once.
- You may submit more than one voucher request for different dates of outpatient services. The amount of reimbursement cannot exceed a total of \$500 per individual.
- The benefits available through this program are limited to individuals employed by DMHAS agencies ONLY. Requests will be processed and paid on a monthly basis with checks mailed directly to the employee requesting the voucher. The employee will remain responsible for paying his/her treatment provider.
- Services covered by the COVID-19 Behavioral Health Assistance Program include the following: individual therapy, group therapy, marital/partner therapy, family therapy and pharmacologic management.
- If you have any questions about completing this form, please contact the COVID-19 Behavioral Health Assistance Program at (866) 213-4759. Additional copies of the Voucher Request Form are available on the ABH website at http://www.abhct.com/Programs_Services/COVID19-BHAP/.
- Your participation by completing a confidential, online survey is requested to assist the agency funding this grant in evaluating the effectiveness of this program. Please indicate on Page 1 of the Voucher Request Form if you are able to participate in this survey and provide your email address. Your willingness to complete this survey will be very much appreciated.
- Voucher Request forms will be accepted if received by 5/13/2022.

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SECTION 2: (To be completed by your treating professional)			
The following information is requested as part of an application for reimbursement of insurance co-pays or deductibles available through the DMHAS COVID-19 Behavioral Health Assistance Program. The information requested below represents the minimum information necessary from the treating practitioner to process this request.			
Patient Name:		Date of Birth:	
Treatment Provider Name:		Provider Phone Number:	
Treatment Service(s) Provided:			
<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Family/Marriage Counseling <input type="checkbox"/> Co-Occurring Treatment <input type="checkbox"/> Group Therapy <input type="checkbox"/> Pharmacologic Management			
DSM DIAGNOSES BEING TREATED (Diagnosis name or code):			
PRIMARY DIAGNOSIS:			
SECONDARY DIAGNOSIS:			
TERTIARY DIAGNOSIS:			
Therapist Signature:			
Signature Date:			

This Voucher Request Form must include the following:

- Voucher Request Form Section 1**
- Voucher Request Form Section 2**
- Insurance Explanation of Benefits Form**

FAX TO: ADVANCED BEHAVIORAL HEALTH, INC.
(860) 704-6145
OR
MAIL TO: ADVANCED BEHAVIORAL HEALTH, INC.
ATT: COVID19 BHAP
213 COURT STREET
MIDDLETOWN, CT 06457