State of Connecticut
Department of Mental Health and Addiction Services

Behavioral Health Recovery Program (BHRP)

Appeal Request and Disposition Form for Recovery Support Services

Applicant Name: _____

Treatment program: _____ Staff Name: _____

If your application has been 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 original denial.

If your appeal denial has been upheld, you may request DMHAS review a second-level appeal within 7 calendar days of the first-level appeal denial.

Encounter #: _____ **Service Being Appealed:** _____

☐ **First-Level Appeal** ☐ **Second-Level Appeal**

Please use the space below and attach any additional pages to explain why you feel the decision should be reconsidered.

_____

_____

_____

_____

_____

_____

Applicant's Signature: _____ Date: _____

Preparer's Signature: _____ Date: _____

Appeal Request Disposition

Outcome: ☐ Upheld ☐ Reversed

Date Received _____/____/_____ **Decision Date**: ____/____/_____

Additional Notes:

ABH/DMHAS Signature:

Please complete and fax this form to ABH at (866) 249-8766.