# Behavioral Health Recovery Program (BHRP)
# Recovery Support Services
# TREATMENT VERIFICATION FORM

Participation in behavioral health treatment is a requirement for individuals to access services through the DMHAS Behavioral Health Recovery Program (BHRP) – Recovery Support Services. This form must be completed by the attesting clinician (or administrative staff with the consent of the attesting clinician) at the provider agency for individuals attending the behavioral health services identified below.

## A. APPLICANT INFORMATION

Applicant's Name: _____

Applicant's Medicaid ID: _____

Applicant's Date of Birth: _____

Applicant's Phone Number: _____

Applicant's Address: _____

## B. BEHAVIORAL HEALTH PROVIDER INFORMATION

Treatment Provider: _____

Provider Address: _____

Level of Care (check one):

Level I: ☐ Outpatient Services ☐ Medication-Assisted Therapies

Level II: ☐ Intensive Outpatient/Partial Hospitalization

Level III: ☐ Residential/Inpatient Services

Treatment Start Date: _____ Expected Discharge Date: _____

## C. PROVIDER ATTESTATION

I attest that the applicant is currently participating in behavioral health treatment/services through the provider agency identified on this form.

_____

Name Agency Contact Number

_____ _____/_____/____

Signature Date

**Please fax the completed form to ABH at 1-866-249-8766**

If there are any questions contact BHRP – RSS staff at 1-800-658-4472.