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: _____

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:

_____

_____

_____

_____

_____

_____

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; 860-418-6690