Behavioral Health Services Integrated Regulations

Clarification Request Form

DATE:	
Provider Name:	**Email:**
Agency Name:	**Phone:**
Name of DHSS/BH Employee Completing or Processing the Form:	
Clarification Request:	
Relevant Citation(s) from Regulations:	
Related References* (if any)**:**	

*(e.g. State Statute Citation(s); Grant Requirement(s); Behavioral Health Services Provider Billing Manual; etc.)

Send Form To: FAX: 907-269-3623, OR
Your T&R Regional Specialist, OR
rick.calcote@alaska.gov