

REIMBURSEMENT REQUEST
 FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY
 ABA THERAPY, EVALUATIONS, CRISIS COUNSELING

RESPONSIBLE PARTY NAME:	CLIENT NAME:
PROVIDER:	MONTH OF SERVICE:
SUPPORT COORDINATOR:	SERVICE:

Total Reimbursement Amount Requested: \$ _____

Total Number of Visits in the Month: _____
 (For purposes when documentation may only show date spans)

Please Attach the Following Required Documentation to Receive Reimbursement (which may be covered by the same document):

- Documentation of insurance payment toward approved service
- Invoice / Statement showing patient responsibility
- If applicable, Progress Notes for services are required when there is no private insurance

TO RECEIVE REIMBURSEMENT, SUBMIT THE COMPLETED FORM WITH THE REQUIRED DOCUMENTATION ATTACHED VIA MAIL OR EMAIL TO THE SERVICE PROCUREMENT SPECIALIST BY THE 5TH OF THE MONTH.

REIMBURSEMENTS MAY BE DELAYED IF NOT SENT AS INDICATED BELOW:

To submit via email:
serviceprocurement@bcfr.org

To submit via mail or in person:
 Boone County Family Resources
 Attn: **Service Procurement Specialist**
 2700 West Ash
 Columbia, MO 65203

SUPPORT COORDINATORS CANNOT RECEIVE REIMBURSEMENT REQUESTS OR SUBMIT ON YOUR BEHALF

I/Our family understand and agree to follow the conditions for participation in the Reimbursement program on the reverse of this form. I/Our family have received and paid for the service(s) listed on this form and hereby request financial reimbursement. If applicable, my insurance has been billed for the service(s) listed on this form. I have not nor will I seek additional reimbursement for the service(s) list on this form.

 Responsible Party/Family Member

 Date

The Boone County Family Resources Reimbursement Program enables families to have more choices in selecting their service providers. Families can be reimbursed for payment to eligible providers. If you have questions about our reimbursement program, please contact your Support Coordinator at 573-874-1995.

CONDITIONS FOR PARTICIPATION IN THE REIMBURSEMENT PROGRAM

Read Carefully

1. Our reimbursement is limited to services/supports prior authorized in the Agency's authorization system. If the authorized amount is incorrect, please contact your Support Coordinator prior to submitting Reimbursement Request.
2. You may submit reimbursement requests at any time during the authorized period, or within 90 days following the last month of the authorized period. All required documentation must be fully completed and submitted together at the same time. Submit all dates of service together for a given month. Additional dates for the month will not be reimbursed after BCFR payment has been processed for that month.
3. Use this form to request reimbursement for:
 - Therapies (PT, OT, Speech, ABA), Evaluations, Crisis CounselingIf you need additional copies of this form contact your Support Coordinator or see the BCFR website at:
<https://www.bcfcr.org/services/support-coordination/funded-services/>
4. Please submit reimbursement requests via mail or email to the attention of the Service Procurement Specialist, at the address noted on the front of this page, by the 5th of the month to allow for reimbursement by the 20th of that month. Any requests received after the 5th of the month or that were not fully completed by the 5th of the month, payment will be mailed by the 20th of the following month.
5. You are responsible to file for all applicable health insurance benefits. You are responsible for your deductible and the agency will only reimburse up to the established unit rate for the service and service duration during this time. You are responsible for any costs that are not covered by your insurance and are in excess of our established unit rate.
6. Reimbursement from this agency will not exceed the authorized amount or the established agency service limits and unit costs.
7. Complete this and other forms electronically or in ink. Please do not use white out. Strike through any errors.