



**BOONE COUNTY FAMILY RESOURCES**

**REIMBURSEMENT REQUEST**

**FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, ABA THERAPY, EVALUATIONS, CRISIS COUNSELING**

<b>RESPONSIBLE PARTY NAME:</b>	<b>CLIENT NAME:</b>	<b>SUPPORT COORDINATOR/ COMMUNITY RESOURCE SPECIALIST:</b>
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Month of Service	Service (OT, PT, ST, ABA, Etc.)	Provider	Number of Visits	Amount Requested	Approved Amount (BCFR USE ONLY)
				\$	
				\$	
				\$	
				\$	
				\$	

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

- ☐ Documentation of insurance payment towards approved service
- ☐ Invoice/Statement showing patient responsibility
- ☐ If applicable, Progress Notes for services: 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 5<sup>TH</sup> 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 56203

**\*SUPPORT COORDINATORS OR COMMUNITY RESOURCE SPECIALISTS 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 service(s) listed on this form.

Responsible Party/Family Member

Date

The Boone County Family Resources (BCFR) 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 or Community Resource Specialist at 573-874-1995.

## CONDITIONS FOR PARTICIPATION IN THE REIMBURSEMENT PROGRAM

*Read Carefully*

1. BCFR's reimbursement limited to services/supports prior authorized in the Agency's authorization system. If you have questions regarding the authorized amount, please contact your Support Coordinator or Community Resource Specialist prior to submitting your Reimbursement Request.
2. You may submit reimbursement requests at any time during the authorized month, or within 95 days after the month of service. 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 the month.

Month of Service	Last Day Paperwork will be Accepted for Reimbursement (95 days after month of service)
January	Tuesday, May 5, 2026
February	Friday, June 5, 2026
March	Monday, July 6, 2026
April	Wednesday, August 5, 2026
May	Monday, September 7, 2026
June	Monday, October 5, 2026
July	Thursday, November 5, 2026
August	Monday, December 7, 2026
September	Tuesday, January 5, 2027
October	Friday, February 5, 2027
November	Friday, March 5, 2027
December	Monday, April 5, 2027

Find and print the 2025 – 2028 Reimbursement Request Deadlines at [www.bcfr.org/services/support-coordination/reimbursed-services/](http://www.bcfr.org/services/support-coordination/reimbursed-services/)

3. Use this form to request reimbursement for:
  - a. Therapies (PT, OT, Speech, ABA), Evaluations, Crisis Counseling

If you need additional copies of this form, contact your Support Coordinator or Community Resource Specialist or see the BCFR website at: [www.bcfr.org/services/support-coordination/reimbursed-services](http://www.bcfr.org/services/support-coordination/reimbursed-services)

4. Please submit complete and accurate 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 5:00 pm on the 5<sup>th</sup> of the month to allow for reimbursement by the 20<sup>th</sup> of that month. Any request received after the 5<sup>th</sup> of the month or that were not fully completed by the 5<sup>th</sup> of the month, payment will be sent by the 20<sup>th</sup> of the following month, once fully completed. If the 5<sup>th</sup> falls on a weekend or holiday of which the Agency is closed, submission of requests are due by 5:00 pm on the following business day.
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 cost 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.