Idaho Substance Use Disorder

Provider Staffing Reimbursement Request

Provider: _____

Facility Code: _____

Mailing Address: _____

_____

_____

Instructions:

All sections below must be completed in order to process this form.

Please fax the form to the BPA Claims Department at: (208) 947-4392
or mail it to: 380 E. ParkCenter Blvd., Ste 300, Boise, ID 83706

To be completed by the Provider:					To be completed by the Authorized Representative of a funding source:		
Date	**Activity/ Description**	**Client Names** *(More than one client may be listed here if they were staffed during this time period.)*	***Number of Units**	***Total units x $6.21**	****Authorized Signature**	**Funding Source: IDHW, IDJC, IDOC, Courts**	**Date signed**
The rate is $6.21 per 1 unit (1 unit = 15 minutes)			**Total:**				

*** Signing this form is confirmation the staffing occurred as listed and will be considered for reimbursement.*

Provider Signature

Date