Acentra HEALTH

COST INVOICE CALCULATION FORM

(To be completed for un-priced codes and submitted with un-altered cost invoice)

Member Name:	
Member Medicaid ID:	
Request Submit Date:	
Authorization Request ID:	

HCPCS Code	Item Description	# of Requested Units (For Supplies, enter # need per month)	Item Cost **(PER UNIT REQUIRED)** (Vendor Cost, not MSR price)	Discount by Vendor (List any primary or secondary discounts per WV Medicaid enrollment contract)	Total amt considered by WV Medicaid AFTER applicable Discount * (Shipping and handling only reimbursed on repairs)	Acentra Health use only: 40% mark-up* if applicable

*40% mark-up (when applicable) is calculated by Acentra Health and is **NOT** to be included on the calculation sheet.

Servicing Provider/Vendor Organization:

Provider/Vendor Contact Name/Phone Number: