



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: