

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 (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)	KEPRO use only: 40% mark-up* if applicable

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

Servicing Provider/Vendor Organization: _____

Provider/Vendor Contact Name/Phone Number: _____