Molina Healthcare of New York
Please Fax to 1-866-879-4742

FINAL COST FORM

Recipient Name: _____ Medicaid CIN: _____

Final cost for (Check One): ☐ Assistive Technology ☐ Environmental Modification ☐ Vehicle Modification

☐ Community Transitional Services (CFCO only) ☐ Moving Assistance (CFCO only)

1. Original Projected Cost: $ _____ Final Cost: $ _____

2. Justify any difference of more than 10% above the original projected cost.

3. Describe the completed service. Attach itemized list of all expenses incurred along with copies of all receipts.

Provider Certification

I certify that the above service was provided in accordance with the above costs.

Service Provider/Agency: _____ Provider Medicaid ID #: _____

Provider Address: _____ Telephone: _____

Provider Contact Name: _____

Provider Contact Signature: _____ Date: _____

Care/Case Manager Certification

I acknowledge that the above service was provided in accordance with the Person-Centered Plan of: Care.

Care/Case Manager Name: _____

Care/Case Manager Signature : _____ Date: _____