INVOICE

Provider Name:
Address:

Phone:
Contact:

Date: Dec 13,2019
Invoice No:

Invoice Purpose:

Bill To:
Molina Healthcare of Washington, Inc
Attn: Finance
PO BOX 4004
Bothell, WA 98041-4004
Phone (425) 424-1100 Fax (844) 541-6841 (toll free)

Begin Date	End Date	CLASSIFICATION	Column1	DESCRIPTION	TYPE OF SERVICE	AMOUNT
		Other	A	Service Days (all clients)	Adult Stabilization	
			B	MHW Service Days		
			C	Monthly Service Expenses		
			D	Sum of Monthly Calendar Days		30
			E	Daily Service Budget		$3,017.47
			F	Max Monthly Reimbursement		$0.00
			G	Invoiced Monthly Reimbursement		
			H	Reimbursement Amount		$0.00
			H	Reimbursement Amount		$0.00
					TOTAL	$0.00

NOTES:
C = Assuming a month's costs of Actual Costs - Less than Budget - TAB "Provider Exp Summary"
D = Assuming a 30 day month
E = Monthly budget based on current contract with RSN divided by 30 days

F = Max Monthly Reimbursement = (E*D)*(B/A) - MHW's proportionate share of current month's budget
G = Monthly Reimbursement = C(B/A) - monthly amount MHW should be responsible for, before the 2.5% admin service fee

H =Reimbursement Amount = 1.025 * (Lessor of F or G)

MHW Provider EXPENSE SUMMARY

DATE: Dec 13,2019
PROVIDER NAME:
SERVICE:
SERVICE Mo & Yr

VARIABLE EXPENSES

TOTAL VARIABLE EXPENSES

FIXED EXPENSES

	_____
	_____
	_____
	_____
	_____
SUB-TOTAL	_____
	_____
TOTAL FIXED EXPENSES	
OTHER EXPENSES	
	_____
	_____
	_____
	_____
TOTAL OTHER EXPENSES	
	_____
TOTAL MONTHLY SERVICE EXPENSES	_____