



**REQUEST FOR PROPOSAL NO. 6100057115
NURSE PEER ASSISTANCE MONITORING PROGRAM**

ATTACHMENT A

COST SUBMITTAL

Supplier Name:	
Supplier Number:	
Mailing Address:	
Supplier Contact Person:	
Telephone Number:	
E-Mail:	

Cost per case, per month listed below shall be in effect for the term of the contract, including any renewals. The term of the contract will be at a fixed cost per case, per month rate for three years, with two one-year renewals options.

Contract is to be invoiced monthly. Invoice is to include an itemized list of open PHMP participant case numbers. Due to HIPPA privacy laws, participant names are to be omitted from the itemized list.

	Cost
Cost Per Case, Per Month	\$

Signature	
<i>Signature of an official authorized to bind the Supplier to the provisions contained in the bid submission:</i>	
Authorized Signature:	
Printed Name:	
Title:	
Date:	