



# HTA VAX Secure Invoice Upload

Tracking Number  
**551**

Date  
**8/6/2021**

## Contract Information

Please enter the contract number first to automatically populate the fields listed with an asterisk (\*) Please note that these fields are "Read Only" and edits are not permitted on the form.

|  |  |                                |  |
|--|--|--------------------------------|--|
| <u>HTA-VAX-202</u><br>Contract Number (required) | <u>LEXINGTON MEDICAL CENTER</u><br>* Contractor Name | <u>85-2276567</u><br>* Tax ID  | <u>7000293108</u><br>* SCEIS Number            |
| <u>Tod Augsburger</u><br>Contact (Full Name)     | <u>President &amp; CEO</u><br>Title                  | <u>(803) 791-2610</u><br>Phone | <u>taugsburger@lexmed.com</u><br>Contact EMAIL |
| <u>2720 sunset blvd</u><br>* Address             | <u></u><br>* STE #                                   | <u>west columbia</u><br>* City | <u>SC 29169</u><br>* State * Zip               |

|                       |                       |
|-----------------------|-----------------------|
| <b>INVOICE NUMBER</b> | <b>INVOICE AMOUNT</b> |
| <u>16</u>             | <u>18,060.00</u>      |

## Please Upload Invoice for Payment Review

To ensure prompt processing of your invoice ensure that you include the invoice number in the file name that you upload. Please ensure that all required information is included on the invoice. Click below for more details

## Secure Document Upload

Please upload the invoice PDF to our secure website using the buttons below.

COVID19 Vaccine Reimbursement Calculator - April 2021 LMC White Knoll High School 4-2-21

I certify that no other funds have been received or will be reimbursed by any other source for the amounts claimed on this invoice

Signature (required) Click to Sign

*Tod Augsburger*  
8/6/2021 10:22:37 AM

\$18,060.00  
Invoice Total

Yes  
 No

The attached invoice is accurate and the invoice total is correct.

ACC Testing Approval

*Bonner, Melissa*  
8/12/2021 10:59:14 AM

Budget and Finance Approval

*Samuels, Tierra B.*  
8/13/2021 9:05:17 AM

Approved Funding \$1,352,963.00

Approved Invoices to Date \_\_\_\_\_

Available Funding \$1,352,963.00

### Payment Processing Instructions

Full Amount \$18,060.00    31070000    Not Relevant    J0402AZ999  
 J040X01048580130    5021310000    98000018

### Accounts Payable Approval

*Robinson, Sharon D.*  
8/17/2021 12:35:56 PM



If rejecting this form for any reason please provide a brief note to the agency. It will be included in the rejection email notification

# COVID-19 Vaccination Reimbursement Request

Inv. 16

## Community Vaccination Event Information\*

|                              |  |
|------------------------------|--|
| Provider Name:               | Lexington Medical Center                     |
| COVID-19 Vaccine Pin Number: | 132120                                       |
| Location Name:               | White Knoll High School                      |
| Location Address (incl zip): | 5643 Platt Springs Rd<br>Lexington, SC 29072 |
| Date & Times:                | April 2, 2021 8am-5pm                        |
| Total # Vaccinations:        | 602  |
| Eligible Vaccinations**:     | 602  |

## Please select yes or no to the following questions to determine eligible reimbursement:

|            |   |
|------------|---|
| <u>Yes</u> | Did your organization provide event management, traffic control and logistics for this event? |
| <u>Yes</u> | Did your organization provide administrative staff for this event?                            |
| <u>Yes</u> | Did your organization provide vaccination staff for this event?                               |

## Reimbursement Calculator

| Item                                    | Rate | Eligible Event Reimbursement |
|---|------|------------------------------|
| Event Mgmt, Traffic, Logistics          | \$10 | \$6,020                      |
| Administrative Staff                    | \$5  | \$3,010                      |
| Vaccination Staff                       | \$15 | \$9,030                      |
| <b>Total Event Reimbursement Amount</b> |      | <b>\$18,060</b>              |

## Additional Cost Summary\*\*\*:

|                                   |            |
|-----------------------------------|------------|
| Total additional cost:            |            |
| Less other funding/reimbursement: |            |
| Net additional cost:              | <b>\$0</b> |

**Total Request Amount: \$18,060**

\* Community Vaccination Events may span multiple days as long as the event location remains the same. All dates should be specified.

\*\* If seeking third-party reimbursement for the services at the event was not appropriate or feasible, then all vaccinations are eligible for reimbursement. If billing third party payers was feasible, then only vaccinations not eligible for insurance reimbursement are eligible for Staffing Reimbursement.

\*\*\* Claiming additional costs requires detailed justification and documentation. Please attach answers to the following questions:

- 1) Summary Description of Request and Costs
- 2) Describe Benefit to the State of South Carolina and Statewide Vaccination Efforts including the future distribution and administering of vaccines.
- 3) Describe activities conducted and outcomes expected or achieved
- 4) Is the cost being covered by any other funding source or insurance? Please explain.
- 5) Were all avenues of funding exhausted before using Vaccine Reserve Account funds? Please explain.