STATE OF TEXAS §
§ **AGREEMENT FOR EMS**
§ **BILLING AND COLLECTION SERVICES**
COUNTY OF COLLIN §

This agreement ("Agreement") is made by and between the City of Allen, Texas ("City") and Advanced Data Processing, dba Intermedix Corporation ("Company") acting by and through their authorized representatives.

Recitals:

WHEREAS, the City desires to engage the services of Intermedix as an independent contractor to provide the services set forth in this Agreement; and

WHEREAS, Intermedix desires to render professional services for the City in accordance with the terms and conditions set forth in this Agreement; and

WHEREAS, the Parties are contracting pursuant to Texas Local Government Code, Chapter 27; and

WHEREAS, Intermedix hereby agrees to provide the City with professional custom emergency medical service billing and collection services in accordance with RFP # 2017-1-37, at the prices set forth in the RFP Response dated February 23, 2017;

NOW THEREFORE, in exchange for the mutual covenants set forth herein and other valuable consideration, the sufficiency and receipt of which are hereby acknowledged, the parties agree as follows:

Article I
Term

1.1 This term of this Agreement shall be for a period of five (5) years, but may be renewed for five (5) additional terms of one (1) year each at the option of the City, by providing Intermedix written notice thereof thirty (30) days prior to the expiration of the then current term.

1.2 Either party may terminate this Agreement by giving thirty (30) days prior written notice to the other party. In the event of such termination, Intermedix shall state in its notice of termination the reasons for such cancellation.

Article II
Scope of Services

2.1 Intermedix shall provide all labor, supervision, materials, and equipment necessary for billing and collection services for emergency medical services ("EMS") provided by the City of Allen Fire Department in accordance with City of Allen's Specifications for EMS

Billing and Collection Services ("City Specifications"), and Intermedix's proposal ("Intermedix's Proposal") in response thereto, copies of which are on file in the City Purchasing Division. The Agreement consists of this written agreement and the following items which are attached hereto and incorporated herein by reference:

a. City Specifications **(Exhibit "A")**;
b. Intermedix's Proposal **(Exhibit "B")**;
c. Insurance Requirements **(Exhibit "C")**;
d. Business Associate Agreement (**Exhibit "D"**); and
e. TripTix Addendum (**Exhibit "E"**).

2.2 These documents make up the Agreement documents and what is called for by one shall be as binding as if called for by all. In the event of an inconsistency or conflict in any of the provisions of the Agreement documents, the inconsistency or conflict shall be resolved by giving precedence first to this written agreement then to the Agreement documents in the order in which they are listed above. These documents shall be referred to collectively as "Agreement Documents."

2.3 In accordance with the items attached hereto and incorporated herein by reference, Intermedix shall:

a. Maintain an average billing system uptime percentage rate of 99.9%, excluding scheduled maintenance.
b. Respond to all emails and telephone calls from City contract administrator, Allen Fire Department, and/or Finance Department within one (1) business day.
c. Make financial reports available to City administrators within 7-10 business days of month end; assuming timely receipt of information needed to close from City.
d. Respond to customer complaints and inquiries within one (1) business day of notification.
e. All billable or clean claims shall be billed within one (1) business day of receiving complete information (*i.e.,* insurance, signatures, CMN, name, address, date of birth and social security number).
f. Intermedix shall maintain an error rate for CMS overbilling and under billing of $\leq 5\%$.
g. Update collections within two (2) business days of when cash receipt information is available to Intermedix.
h. Maintain database and data query access from 7:00 a.m. to 7:00 p.m. (Central Time) ("Business Hours") during normal business days (Monday through Friday, excluding national holidays).

Article III
Compensation

3.1 The City shall compensate Intermedix 5.95% of amount collected for the billing and collection service as outlined in Intermedix's proposal submitted and attached hereto in Exhibit "B." The City Fire Administration will act as a lockbox, and receive all payments sent in check form. The City will scan and send electronic copies of checks received to Intermedix, All other correspondence and Explanation of Benefits are to be sent directly to Intermedix at an address provided by Intermedix. All funds are sent to the City and Intermedix shall submit an invoice for compensation due.

3.2 Unless otherwise provided herein, Intermedix shall be responsible for all expenses related to the services provided pursuant to this Agreement including, but not limited to, travel, copying and facsimile charges, telephone, internet and email charges, record and data storage, maintenance of computer laptops, and software and hardware expenses, including but not limited to EPCR software and hardware, unless otherwise provided herein.

3.3 Intermedix recognizes that this Agreement shall commence upon the day first written above and continue in full force and effect until termination in accordance with its provisions. Intermedix and City herein recognize that the continuation of any agreement after the close of any given fiscal year of the City, which fiscal year ends on September 30th of each year, shall be subject to City Council approval. In the event that the City Council does not approve the appropriation of funds for this Agreement, the Agreement shall terminate at the end of the fiscal year for which funds were appropriated and the parties shall have no further obligations hereunder.

Article IV
Billing and Audit Standards

4.1 Intermedix warrants and represents that it maintains adherence to the Office of Inspector General of the Department of Health and Human Services Compliance Program Guidance for billing companies as published in the Federal Register.

4.2 Intermedix agrees to comply with all applicable federal and state laws, including "anti-kickback," "excessive charges," and other regulations relevant to this Agreement.

4.3 The City represents and warrants that it is not excluded from participation in any state and/or federal health care programs. The City further agrees to notify Intermedix within five (5) business days of City's discovery that it is the subject of any actions, investigations or other proceedings that could lead to its exclusion from any state and/or federal health care programs.

4.4 The City represents and warrants that it is permitted by law to charge a fee and/or otherwise bill and be paid for its services, and that the City Council shall set the general schedule of fees and charges for applicable services. Intermedix shall determine the eligibility of the services rendered for payment according to applicable reimbursement laws, rules or policies.

4.5 The City represents that it will submit truthful and accurate facts and documentation to Intermedix for billing purposes. The City understands that Intermedix shall rely upon the documentation and factual representations made to it by City regarding the eligibility of the services rendered for payment according to applicable reimbursement laws, rules or policies. Intermedix shall determine the proper coding for billing purposes based on the description of services provided by City.

4.6 Intermedix shall provide electronic patient care report (EPCR) software and hardware for City use. Specifically, Intermedix shall provide the City with six (6) rugged mobile pen tablet based computer laptops with wireless connectivity. Contractor is to maintain all rugged laptop computers in working condition (condition where all hardware and software is functioning properly to complete the required services in the manner specified). Hardware replacement shall be every 3.5 years throughout the contract. Intermedix shall also provide, at no additional cost to the City, one (1) additional rugged laptop for daily use when an additional ambulance is added to service. Intermedix is also to provide cardiac monitor cables, at no additional cost for daily use Toughbooks.

4.7 Intermedix will advise and assist the City to meet or exceed the Centers for Medicare and Medicaid Services (CMS) revalidation requirements throughout the term of the contract. All filing fees and CMS charges shall be the responsibility of the City.

Article V
Devotion of Time; Personnel; and Equipment

5.1 Intermedix shall devote such time as reasonably necessary for the satisfactory performance of the work under this Agreement. Should the City require additional services not included under this Agreement, Intermedix shall make reasonable effort to provide such additional services at mutually agreed charges or rates, and within the time schedule prescribed by the City; and without decreasing the effectiveness of the performance of services required under this Agreement.

5.2 To the extent reasonably necessary for Intermedix to perform the services under this Agreement, Intermedix shall be authorized to engage the services of any agents, assistants, persons, or corporations that Intermedix may deem proper to aid or assist in the performance of the services under this Agreement. The cost of such personnel and assistance shall be borne exclusively by Intermedix.

5.3 Intermedix shall furnish the facilities, equipment, telephones, facsimile machines, email facilities, software, hardware, and personnel necessary to perform the services required under this Agreement unless otherwise provided herein.

Article VI
Miscellaneous

6.1 Entire Agreement. This Agreement constitutes the sole and only agreement between the parties and supersedes any prior understandings written or oral agreements between the parties with respect to this subject matter.

6.2 Ownership of Patient Accounts. Ownership of all accounts shall remain with the City of Allen. In the event of termination of the Contract for any reason, all accounts shall be returned to the City of Allen regardless of payments made on account or arrangements granted.

6.3 Assignment. Intermedix may not assign this Agreement in whole or in part without the prior written consent of City. In the event of an assignment by Intermedix to which the City has consented, the assignee shall agree in writing with the City to personally assume, perform, and be bound by all the covenants, and obligations contained in this Agreement.

6.4 Successors and Assigns. Subject to the provisions regarding assignment, this Agreement shall be binding on and inure to the benefit of the parties to it and their respective heirs, executors, administrators, legal representatives, successors and assigns.

6.5 Compliance with Applicable Laws. Intermedix shall at all times observe and comply with all Federal, State and local laws, ordinances and regulations including all amendments and revisions thereto, which in any manner affect Intermedix or the work, and **SHALL INDEMNIFY AND SAVE HARMLESS CITY AGAINST ANY CLAIM RELATED TO OR ARISING FROM THE VIOLATION OF ANY SUCH LAWS, ORDINANCES AND REGULATIONS WHETHER BY INTERMEDIX, ITS EMPLOYEES, OFFICERS, AGENTS, SUBCONTRACTORS, OR REPRESENTATIVES.** If Intermedix observes that the work is at variance therewith, Intermedix shall promptly notify City in writing.

6.6 Governing Law. The laws of the State of Texas shall govern this Agreement without regard to any conflict of law rules; and venue for any action concerning this Agreement shall be in the State District Court of Collin County, Texas. The parties agree to submit to the personal and subject matter jurisdiction of said court.

6.7 Amendments. This Agreement may be amended by the mutual written agreement of the parties.

6.8 Severability. In the event any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not effect any other provisions, and the Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained in it.

6.9 Independent Contractor. It is understood and agreed by and between the parties that Intermedix in satisfying the conditions of this Agreement, is acting independently, and that

the City assumes no responsibility or liabilities to any third party in connection with these actions. All services to be performed by Intermedix pursuant to this Agreement shall be in the capacity of an independent contractor, and not as an agent or employee of the City. Intermedix shall supervise the performance of its services and shall be entitled to control the manner and means by which its services are to be performed, subject to the terms of this Agreement.

6.10 Notice. Any notice required or permitted to be delivered hereunder may be sent by first class mail, overnight courier or by confirmed telefax or facsimile to the address specified below, or to such other party or address as either party may designate in writing, and shall be deemed received three (3) days after delivery set forth herein:

If intended for City:
City of Allen, Texas
Attn: Peter H. Vargas, City Manager
305 Century Pkwy.
Allen, Texas 75013
Facsimile: 214-509-4118

With copy to:
Peter G. Smith
Nichols, Jackson, Dillard, Hager & Smith, L.L.P.
500 N. Akard, 1800 Lincoln Plaza
Dallas, Texas 75201
Facsimile: 214-965-0010

If intended for Company:
Advanced Data Processing dba Intermedix
6451 N. Federal Highway, Suite 1000
Fort Lauderdale, FL 33308
Facsimile: 954-308-8725

6.11 Counterparts. This Agreement may be executed by the parties hereto in separate counterparts, each of which when so executed and delivered shall be an original, but all such counterparts shall together constitute one and the same instrument. Each counterpart may consist of any number of copies hereof each signed by less than all, but together signed by all of the parties hereto.

6.12 Exhibits. The exhibits attached hereto are incorporated herein and made a part hereof for all purposes.

6.13 Indemnification.

(a) **INTERMEDIX AGREES TO DEFEND, INDEMNIFY AND HOLD THE CITY AND ITS RESPECTIVE OFFICERS, AGENTS AND EMPLOYEES, HARMLESS AGAINST ANY AND ALL CLAIMS, LAWSUITS, JUDGMENTS, FINES, PENALTIES, COSTS AND EXPENSES FOR PERSONAL INJURY (INCLUDING DEATH), PROPERTY DAMAGE, INTELLECTUAL PROPERTY INFRINGEMENT CLAIMS (INCLUDING PATENT, COPYRIGHT AND TRADEMARK INFRINGEMENT) OR OTHER HARM OR VIOLATIONS FOR WHICH RECOVERY OF DAMAGES, FINES, OR PENALTIES IS SOUGHT, SUFFERED BY ANY PERSON OR PERSONS, TO THE EXTENT THAT THEY MAY ARISE**

OUT OF OR BE OCCASIONED BY INTERMEDIX'S BREACH OF ANY OF THE TERMS OR PROVISIONS OF THIS AGREEMENT, VIOLATIONS OF LAW, OR BY ANY NEGLIGENT, GROSSLY NEGLIGENT, INTENTIONAL, OR STRICTLY LIABLE ACT OR OMISSION OF INTERMEDIX, ITS OFFICERS, AGENTS, EMPLOYEES, INVITEES, SUBCONTRACTORS, OR SUB-SUBCONTRACTORS AND THEIR RESPECTIVE OFFICERS, AGENTS, OR REPRESENTATIVES, OR ANY OTHER PERSONS OR ENTITIES FOR WHICH INTERMEDIX IS LEGALLY RESPONSIBLE IN THE PERFORMANCE OF THIS AGREEMENT. THE INDEMNITY PROVIDED FOR IN THIS PARAGRAPH SHALL NOT APPLY TO ANY LIABILITY RESULTING FROM THE SOLE NEGLIGENCE OF THE CITY, AND ITS OFFICERS, AGENTS, EMPLOYEES OR SEPARATE CONTRACTORS. THE CITY DOES NOT WAIVE ANY GOVERNMENTAL IMMUNITY OR OTHER DEFENSES AVAILABLE TO IT UNDER TEXAS OR FEDERAL LAW. THE PROVISIONS OF THIS PARAGRAPH ARE SOLELY FOR THE BENEFIT OF THE PARTIES HERETO AND ARE NOT INTENDED TO CREATE OR GRANT ANY RIGHTS, CONTRACTUAL OR OTHERWISE, TO ANY OTHER PERSON OR ENTITY.

(b) INTERMEDIX AT ITS OWN EXPENSE IS EXPRESSLY REQUIRED TO DEFEND CITY AGAINST ALL SUCH CLAIMS TO THE EXTENT SUCH CLAIMS RELATE TO INTERMEDIX. CITY RESERVES THE RIGHT TO PROVIDE A PORTION OR ALL OF ITS OWN DEFENSE; HOWEVER, CITY IS UNDER NO OBLIGATION TO DO SO. ANY SUCH ACTION BY CITY IS NOT TO BE CONSTRUED AS A WAIVER OF INTERMEDIX'S OBLIGATION TO DEFEND CITY OR AS A WAIVER OF INTERMEDIX'S OBLIGATION TO INDEMNIFY CITY PURSUANT TO THIS AGREEMENT. INTERMEDIX SHALL RETAIN DEFENSE COUNSEL WITHIN SEVEN (7) BUSINESS DAYS OF CITY'S WRITTEN NOTICE THAT CITY IS INVOKING ITS RIGHT TO INDEMNIFICATION UNDER THIS AGREEMENT. IF INTERMEDIX FAILS TO RETAIN COUNSEL WITHIN THE REQUIRED TIME PERIOD, CITY SHALL HAVE THE RIGHT TO RETAIN DEFENSE COUNSEL ON ITS OWN BEHALF AND INTERMEDIX SHALL BE LIABLE FOR ALL COSTS INCURRED BY THE CITY.

(c) IN ADDITION TO INTERMEDIX'S INTELLECTUAL PROPERTY INFRINGEMENT INDEMNIFICATION AND DEFENSE REQUIREMENTS HEREIN, IF AN INFRINGEMENT CLAIM OCCURS, OR IN INTEREMDIX'S OPINION IS LIKELY TO OCCUR, INTERMEDIX SHALL, AT ITS EXPENSE: (A) PROCURE FOR THE CITY THE RIGHT TO CONTINUE USING THE PRODUCT; (B) REPLACE OR MODIFY THE PRODUCT SO THAT IT BECOMES NON-INFRINGING WHILE PROVIDING FUNCTIONALLY EQUIVALENT PERFORMANCE; OR (C) ACCEPT THE RETURN OF THE PRODUCT AND GRANT THE CITY A

REIMBURSEMENT FOR THE PRODUCT. INTERMEDIX WILL PROCEED UNDER SUBSECTION (C) ABOVE ONLY IF SUBSECTIONS (A) AND (B) PROVE TO BE COMMERCIALLY UNREASONABLE.

(d) **THE INTELLECTUAL PROPERTY INFRINGEMENT INDEMNIFICATION HEREIN APPLIES TO ALL PRODUCTS PROVIDED, SUPPLIED OR SOLD UNDER THIS AGREEMENT BY INTERMEDIX TO CITY WHETHER MANUFACTURED BY INTERMEDIX OR A THIRD PARTY. INTERMEDIX REPRESENTS THAT, TO THE BEST OF ITS KNOWLEDGE, THE CITY'S USE OF PRODUCTS THAT ARE PROVIDED SUPPLIED, OR SOLD BY INTERMEDIX TO CITY AS PART OF THIS AGREEMENT DOES NOT CONSTITUTE AN INFRINGEMENT OF ANY INTELLECTUAL PROPERTY RIGHTS AND THE CITY HAS THE LEGAL RIGHT TO USE SAID PRODUCTS. THE CITY ENTERS INTO THIS AGREEMENT RELYING ON THIS REPRESENTATION.**

(e) **THE INDEMNIFICATION HEREIN SURVIVES THE TERMINATION OF THE AGREEMENT AND/OR DISSOLUTION OF THIS AGREEMENT INCLUDING ANY INFRINGEMENT CURE PROVIDED BY INTERMEDIX PURSUANT TO PARAGRAPH 3 IN THE HEREIN INDEMNIFICATION SECTION.**

6.14 Audits and Records. Intermedix agrees that during the term hereof the City and its representatives may, during normal business hours and as often as deemed necessary, inspect, audit, examine and reproduce any and all of Intermedix's records relating to the services provided pursuant to this Agreement for a period of one year following the date of completion of services as determined by the City or date of termination if sooner.

6.15 Conflicts of Interests. Intermedix represents that no official or employee of the City has any direct or indirect pecuniary interest in this Agreement.

6.16 Insurance.

(a) Intermedix shall during the term hereof maintain in full force and effect the following insurance: (1) a policy of insurance for bodily injury, death and property damage insuring against all claims, demands or actions relating to the Intermedix's performance of services pursuant to this Agreement with a minimum combined single limit of not less than $1,000,000 Dollars per occurrence for injury to persons (including death), and for property damage; (2) policy of automobile liability insurance covering any vehicles owned and/or operated by Intermedix, its officers, agents, and employees, and used in the performance of this Agreement; and (3) statutory Worker's Compensation Insurance covering all of Intermedix's employees involved in the provision of services under this Agreement.

(b) All insurance and certificate(s) of insurance shall contain the following provisions: (1) name the City, its officers, and employees as additional insureds as to all applicable coverage with the exception of Workers Compensation Insurance and Professional Liability; (2) provide for at least thirty (30) days prior written notice to the City for cancellation or non-renewal of the insurance; and (3) provide for a waiver of subrogation against the City for injuries, including death, property damage, or any other loss to the extent the same is covered by the proceeds of insurance, except for Professional Liability Insurance. Intermedix shall provide written notice to the City of any material change of or to the insurance required herein.

(c) All insurance companies providing the required insurance shall either be authorized to transact business in Texas and rated at least "A" by AM Best or other equivalent rating service, or approved by the City Risk Manager.

(d) A certificate of insurance evidencing the required insurance shall be submitted to the City prior to commencement of services.

(signature page to follow)

EXECUTED this _____ day of _____, 2017.

CITY OF ALLEN

By: _____
PETER H. VARGAS, CITY MANAGER

Allen Civic Plaza
305 Century Parkway
Allen, Texas 75013

ATTEST

_____
SHELLEY B. GEORGE, CITY SECRETARY

EXECUTED this 14th day of April, 2017.

ADVANCED DATA PROCESSING INC, DBA INTERMEDIX
COMPANY

By: _____
Signature of Authorized Officer

Name: BRAD WILLIAMS
Print Name

Title: VP & CAO

6451 N. Federal Highway, Suite 1000
Fort Lauderdale, FL 33308

EXHIBIT "A"
SPECIFICATIONS

SECTION III

OVERVIEW & BACKGROUND INFORMATION

GENERAL

The City of Allen (COA) is soliciting bids for a contract to provide Emergency Medical Services (EMS) Billing and Collection Services meeting no less than the following minimum requirements.

The successful vendor will provide a total solution to include but not limited to, hardware, electronic patient care report (EPCR) software, billing and collections services.

CONTRACT TERM

The term of the Agreement, if awarded, shall begin on the last date of execution hereof (the "Effective Date") and continue for a period of five (5) years.

City maintains the right to renew this Agreement for up to five (5) additional renewal terms of one (1) year at the City's sole discretion. The City may exercise its right to renew this Agreement by providing Company written notice thereof thirty (30) days prior to the expiration of the Initial Term or renewal term, as the case may be.

Unless otherwise amended in writing and endorsed by both parties prior to the beginning of each respective renewal period, all terms and conditions of the Contract shall remain in full force and effect with the only change being in the Contract term.

OVERVIEW

This contract, if awarded, will be administered by the City of Allen Fire Department with technical oversight provided by the City of Allen Finance Department.

The services requested include: locating and billing EMS service recipients, individual and third party clients, filing and collecting payments from private insurance, Medicare, Medicaid, Tricare, etc. The successful vendor will also collect delinquent accounts in accordance with the City of Allen billing philosophy.

The City will compensate the Contractor with a percentage of the amount collected on a monthly basis. The Contractor shall compile all receipts for the City, double check the proper posting and documentation, and finally prepare the receipts for weekly shipment to the City, via 2-day FedEx delivery to the designated location. All funds are sent to the City for deposit and the Contractor shall submit an invoice on a monthly basis for compensation due.

Should any additional and similar billing and collection services be required by the City of Allen Fire Department, the Contractor will be expected to offer a comparable pricing structure for such services as is offered on the services specified herein.

The Contractor shall enter and transmit reportable run data to outside agencies, including but not limited to Texas Trauma Registry and Texas Department of State Health Services

The prices offered the City of Allen and indicated on the Proposal shall be inclusive of any and all costs associated with providing the specified service(s), e.g., salaries and benefits, materials and supplies, and overhead and profits.

The amount proposed shall be stated as a percentage of the amount of monies collected. Alternate pricing structures will not be considered.

ALLEN FIRE DEPARTMENT BACKGROUND

The Allen Fire Department provides emergency medical services within the Allen city limits and neighboring jurisdictions through mutual aid agreements. The City of Allen Fire Department operates four (4) ambulances and completes approximately three thousand (3000) billable ambulance runs each year.

The City of Allen has established rates and fees for the use of EMS services. The fee for emergency ambulance service is $855 per patient per call for resident and non-resident users, plus a mileage fee of $15 per mile to an area hospital with a certified Emergency Department. The patient will also receive an itemized bill for procedures performed as well as medications and disposable supplies utilized in their care.

It shall be noted that the City of Allen will accept a resident's insurance, including Federal Health Care Programs, as "payment in full" for Emergency Ambulance Services (insurance only billing for residents of Allen).

It is the philosophy of the City that all work performed under this contract shall be of the highest professional standards and shall in every respect meet or exceed standard industry practice and comply with the Fair Debt Collection Practices Act. No harassing or "strong-arm" tactics shall be employed. The City will not permit the contractor to subcontract billing or collection activities to a third party billing or collection agency.

EMS COLLECTION HISTORY

FY 2013 $1,341,620.74
FY 2014 $1,262,895.88
FY 2015 $1,296,799.52
FY 2016 $1,235,922.35

SECTION IV
SPECIFICATIONS AND REQUIREMENTS

SCOPE OF WORK

Contractor shall set up, maintain and provide all aspects to include but not limited to EMS reporting, billing and collection services for the City of Allen Fire Department.

The successful contractor under this contract will provide all services necessary to report, bill and collect for services provided by City of Allen Fire Department EMS. These services shall include but not be limited to:

Perform the billing, collection and generation of any and all insurance forms and filings, record maintenance and preparation of standard or custom reports as requested or required for EMS services.

Provision of six (6) rugged mobile pen tablet based computer laptops with wireless connectivity. Contractor is to maintain all rugged laptop computers in working condition (condition where all hardware and software is functioning properly to complete the required services in the manner specified). Hardware replacement shall be every 3.5 years throughout the contract.

Provision of electronic patient care reporting (EPCR) software to be used on the rugged mobile pen tablet based computer laptops. This software should be configured to the City of Allen's specifications. Information that should be gathered by the EPCR software can be found in SECTION V Technical Specifications.

Perform training of designated City of Allen personnel on EPCR and other applications as requested by the City of Allen.

Enter and transmit reportable run data to outside agencies, including but not limited to Texas Trauma Registry and Texas Department of State Health Services.

BIDDER QUALIFICATIONS

Each respondent to this proposal shall be capable of meeting the following minimum requirements:

1. The Contractor shall be equipped with computer operations to receive and send data electronically. Facsimile transmissions and mail or courier services shall be held to a minimum.

2. The Contractor shall possess and maintain nationwide billing and collection capabilities.

3. The Contractor shall have and maintain a trained staff with experience working with Medicare, Medicaid, Worker's Compensation, Tricare and commercial insurance companies, as well as individual debtors.

4. The Contractor will maintain compliance with the Health Information Privacy and Portability Act (HIPPA), as amended.

5. The Contractor shall have an internal audit processes for internal procedures and compliance with all federal, state and local regulations and laws.

6. A process to provide and maintain a data base or data warehouse of accessible information for all billing and collection information. This data base or data warehouse must be accessible by designated City employees via the web for the purpose of identifying and retrieving information in a variety of report formats.

7. The Contractor shall have a detailed Data Plan which addresses issues of security, information availability, data storage and duplication, and an emergency recovery plan.

8. The Contractor shall have the ability to maintain records of all services performed and all financial transactions for each ambulance run.

9. Respondents shall at a minimum, be in the process of completing a Statement of Auditing Standards (SAS) 70 Type II certification which demonstrates an unqualified opinion, as recognized by the American Institute of Certified Public Accountants (AICPA) at the time of contract award. ***A copy of the proof of process engagement or a copy of a previously completed audit must be submitted with the proposal. If submitting proof of process engagement, a complete report including management comments shall be submitted to the City of Allen when completed.***

10. A compliance program in place that meets or exceeds the Department of Health and Human Services Office of Inspector General (OIG) Compliance Program Guidance for Third-Party Medical Billing Companies. ***A copy of the service agency's program shall be submitted with the proposal.***

11. A program that is fully compliant with the Federal Trade Commission's Red Flag Rules and must provide the City with all updates throughout the term of the contract. ***A copy of the service agency's Red Flag Rules compliance plan shall be submitted with the proposal.***

12. The ability to gather, extract, and transmit data collected from patient run information to satisfy the reporting requirements the Allen Fire Department has to all outside agencies including but not limited to the Texas Trauma Registry and the Texas Department of State Health Services.

13. The contractor shall have a process to keep current with the allowable rates of Medicare, Medicaid and all insurance providers.

14. The contractor shall have a process to maintain and keep active any and all certifications required such as, Medicare and Medicaid on the behalf of City of Allen.

15. The contractor shall provide electronic patient care report (EPCR) software and hardware for City use. Please see Section V, Technical Specifications, for technical specifications on EPCR software and hardware.

SPECIAL TERMS & CONDITIONS

SERVICES

The Contractor shall provide umbrella billing services on behalf of the City of Allen's Emergency Medical Services. This umbrella service includes, but is not limited to, identifying on a quarterly basis the reasonable and customary amount allowable by insurance carriers, for basic and advanced life support services. Furthermore, the Contractor shall use all available means to ascertain the liable insurance carrier for any client for whom that information is otherwise unavailable.

BILLING PROCESSES

The resulting contract will require the selected vendor to provide billing activities for both current and delinquent accounts, in accordance with all federal, state and local regulations and laws, and standard industry practices. The City requires that all debtors are treated fairly, with professionalism, honesty and integrity while obtaining maximum collection results.

INITIAL BILLING

All initial insurance/Medicare/Medicaid billings shall be accomplished within three (3) business days after the Contractor receives the information and a minimum of one (1) reminder notice shall be transmitted within thirty (30) days after the initial invoicing to remitters who have failed to make payment or payment arrangements.

PATIENT ACCOUNTS

Ownership of the accounts shall remain with the City of Allen. In the event of termination of the Contract for any reason, all accounts shall be returned to the City of Allen upon request.

INFORMATION OWNERSHIP
The City of Allen Fire Department is the owner of all information submitted to the Contractor. If this agreement is terminated, all accounts will be returned to the City of Allen regardless of payments made on account or arrangements granted.

At completion of contract or termination, contractor agrees to provide a raw flat file (file shall not require the use of any proprietary software to be used) containing all relevant data that would be needed to re-create an electronic patient care report for any purpose. The contractor agrees to provide the City a one-time column header file with a brief description of each column's data and how it pertains to the formulation necessary to re-create the electronic patient care record.

INFORMATION SECURITY
The contractor is required to notify the City of Allen if any submitted information or any record where the City of Allen is the owner is compromised or suspected to be compromised.

PERFORMANCE MEETINGS
The contractor will be required to meet with the City of Allen at a minimum semi-annually; actual frequency of meetings will be coordinated between City of Allen Fire Department and contractor. The purpose of these meetings will be to present reports, give notification of regulatory changes or issues, to discuss performance, and other information relevant to the contract.

PATIENT CONTACT
Patient Contact - Billing:
Contractor shall provide and maintain a billing office on behalf of the City of Allen EMS. As required, Contractor will file Health Insurance Claim Forms in the name of the City of Allen with insurance companies, Medicaid, Medicare, Workers Compensation or others in an attempt to facilitate payment of a Patient's EMS bill. Contractor may for billing information purposes only mail, telephone or otherwise contact Patients, the responsible party, their insurance company, Medicaid, Medicare, Workers Compensation or others in order to gather information necessary to develop and send the bill.

Patient Contact - Delinquent Accounts:
If a Patient's account becomes delinquent, Contractor may only mail collection notices in an attempt to collect those delinquent accounts. Phone or other contact in an attempt to collect the account is not acceptable or allowed. Form letter to be approved by Allen Fire Department prior to use.

Correct Information:
The Contractor may rely on the City of Allen (COA) to provide correct information about the patient's bill and specifically about the dollar amount in question, and the COA will immediately update and correct any information it has provided to the Contractor. In particular, the COA will immediately notify the Contractor of any payment or other satisfaction of the account made directly to the COA or any other action affecting the amount or timing of monies owed by the Patient to the COA.

Legal Action/Credit Bureaus:
The COA does NOT authorize the Contractor to report delinquent accounts to the credit bureau(s). Contractor shall have no liability for any amount uncollected and in no event shall be required or authorized to bring any suit for the collection of any such uncollected amount.

COMMISSIONS ON ACCOUNTS COLLECTED
Commission Rate
For all accounts referred by the COA to Contractor for billing for which payment is made (in whole or in part), Contractor will be paid a percentage of amount collected as a commission.

Notification of Collections
The COA will immediately forward to the Contractor copies of account payments or account disputes that have been submitted directly to the COA.

Rate Schedule for Patient Care Services Rendered
The COA will instruct the Contractor to develop a patient's bill based upon a defined rate schedule. The COA will update the rate schedule subject to Council approval. The COA will generally follow the rate schedule published by the Centers for Medicare & Medicaid Services (CMS). The Contractor must also agree that the COA may change any rate specified on the schedule at any time upon 30 days written notice to the Contractor.

The Contractor shall provide at their expense, software to be loaded on COA computer equipment (if applicable) for the entry of patient care information necessary to generate the patient bill. The COA shall incur no initial or on-going costs associated with the software or transmission of data between the COA and the service.

Collections
The Contractor shall manage all aspects of the collection and documentation of the billed accounts. This includes but is not limited to receiving, recording, and tracking payments from patients and/or insurance companies. The Contractor shall provide a record of the collection status of accounts each week. All funds received shall also accompany the collection status report for deposit by the COA.

Collection of Charges, Co-Payments
The Contractor will attempt to collect all amounts due and owing the COA in accordance with the established rate schedule (Refer to billing philosophy as stated in Section III, AFD Background). However, the COA, may, at any time, provide alternative instructions with respect to any account, any payment amount or any arrangement to be made. The COA is limited to giving the Contractor alternative instructions with respect to no more than 15 accounts at any time.

Alternative Collection Arrangements when Full Payment Unavailable
The Contractor will have the ability, on the COA's behalf, to enter into an alternative collection arrangement with respect to any patient bill if:

The total payments are for at least 80 percent of the amount of the bill and the length of the payments does not exceed 18 months;

An insurance company offers at least 70% of the total amount billed with a stipulation that the insured not be billed for the balance; or

The Contractor is able to make any arrangements for the payment of a patient account that provide a substantially similar economic benefit to the COA, as the Contractor determines in its sole and complete discretion.

Location for Payments
The Contractor must serve as the primary location to accept payments and may accept payments in the name of the COA or the Contractor. Copies of payments received at the COA shall be forwarded to the service for processing.

The Contractor shall deliver all collections to City of Allen for deposit by the last business day of each week. The address for delivery is: City of Allen, Central Fire, 310 Century Parkway, Allen, Texas 75013.

Scope of Collection Efforts
If reasonable efforts have been made to collect an account and such efforts have not been successful, the Contractor shall terminate collection efforts and close the account as an unpaid debt. As used herein "reasonable efforts" shall be defined to mean between 90 and 150 days of active collection efforts in the ordinary course of business. Reasonable efforts include contact my mail only. Phone calls and/or personal contact are deemed unreasonable. The service has no claim on uncollected accounts and may not sell or outsource collection efforts to another party.

Telephone Support
The Contractor will provide patients and personnel of the COA with toll free telephone support services during normal business hours (Monday - Friday from 9:00 a.m. to 5:00 p.m.) except on public holidays or other holidays as established via agreement between the Contractor and the COA.

REMITTANCE REQUIREMENTS
All collections shall be delivered to the COA on a weekly basis for deposit. All collections with supporting documentation and contractor invoices shall be submitted to:

City of Allen Fire Department
310 Century Parkway
Allen, Texas 75013

Contractor shall submit invoices monthly with supporting documentation to the address above.

DATA COLLECTION AND TRANSMISSION SERVICES
Electronic Storage of Run Details
The Contractor shall provide, at no additional cost to the City of Allen (COA), a secure server connection for submission of client data by paramedics via a personal computer on the COA's Local Area Network, or by such web browser based devices as may be securely connected to Contractor's server(s) via wireless connectivity.

Data Transmission
The Contractor shall cause the client data (patient run report), when complete, to be transmitted electronically to the health care facility that received, or will receive, the patient.

Administrative Data Access
The Contractor shall supply, at no additional cost to the COA, a secure connection method from the COA's Local Area Network to the databases containing run data for supervisory, administrative, financial, audit, records, and medical direction personnel. Access shall be limited to each user or group according to what those users are procedurally or legally entitled to use by COA management.

Collection Data Access
The Contractor shall make available to COA staff, via secure Web connection, all information regarding date of the invoicing, date of any/all follow-ups, if needed, the date of the receipt of payment and the amount of payments received as well as the balanced owed for each individual account.

State/Other Agency Reporting requirements
The Contractor shall enter and transmit reportable run data to outside agencies, including but not limited to Texas Trauma Registry and Texas Department of State Health Services.

Provision of Copies
From time-to-time, patients or their representatives may request copies of medical records maintained by the Contractor. The service may charge a reasonable fee for the provision of these documents. The Contractor shall establish and submit a list of such fees.

Training for System
Upon written request from the COA, the Contractor will provide at no cost to the COA onsite training classes on the use of any software and/or hardware provided by the service.

Provision of Data Entry Devices
The COA and the Contractor understand and agree that the Contractor shall make available data entry devices (hand-held devices, tablet pc's and/or other data entry devices for the collection and/or transmission of medical information). The Contractor shall provide these devices, software, and all other hardware, software, and associated services and maintenance/upgrades at no additional cost to the COA. If the COA damages the hardware, the COA will only be charged actual cost to repair or replace the item. Normal wear and tear is excluded.

Wireless Access
Contractor shall provide at no initial or on-going cost the ability to wirelessly transmit data from the hand-held devices, tablet pc's and/or other portable data entry devices. Wireless access shall be provided using regional cellular or other similar networks without the use of COA network access. The contractor shall provide wireless access devices, software, and all other hardware, software, and associated services and maintenance/upgrades at no additional cost to the COA. If the COA damages the hardware, the COA will only be charged actual cost to repair or replace the item. Normal wear and tear is excluded.

COA PROVIDED INFORMATION

Notification of the ambulance run along with the client information will be provided within one (1) week after the run occurs.

At the time of the run, COA personnel will attempt to collect the following data, which will make available to the Contractor:

Client's Name
Client's Home Address
Client's Home Telephone Number
Client's Social Security Number
Client's Driver's License Number and State of issuance
Date and location of service
Name of Client's insurance carrier
Client's Insurance Policy or Group information

SECTION V
TECHNICAL SPECIFICATIONS

Contractor shall supply EPCR software and necessary hardware meeting these minimum requirements.

The following information shall be gathered by the EPCR software should include but not be limited to:

A. Incident address with zip code
B. Patient personal information including, but not limited to:
    1. Social Security number
    2. Address
    3. Telephone Number
    4. Date of birth, weight, age, gender, and race
    5. Family Physician
    6. Medicaid State
    7. Medicaid Number
    8. Medicare Number
    9. Medicare plus plan name
    10. Insurance Number
    11. Group Number
    12. Secondary Insurance Number
    13. Secondary Group Number
    14. Guarantor Information
    15. Documentation of patient or guardian release of patient information for billing, including a digitized patient or guardian signature captured in multiple languages, and supports hand writing recognition.
    16. Supports additional billing inputs (i.e. additional supplies such as foam usage or additional medications)
    17. Information about the medical condition and complaints of the patient including but not limited to:
        a. Cause of injury
        b. Trauma triage
        c. Patient position information
        d. Medical condition(s) and systems details
        e. Narratives by the care providers regarding the incident
        f. Ability to enter multiple patients
    18. Unlimited primary and secondary assessment information including, but not limited to:
        a. Glasgow Coma Scale (GCS) scoring automatically calculates a total
        b. Revised trauma score, scoring automatically calculates a total
        c. Pupil size and reaction
        d. Capillary refill
        e. Respiratory assessment

f. ECG
g. Ectopy
h. Blood glucose level
i. Skin Color
j. Temperature
k. Moisture
l. Lung Sounds
m. Times of vital signs
n. Appearance Pulse Grimace Activity Reparations (APGAR) scores (if applicable)
o. Neurological assessment information
p. Medical History including, but not limited to:
    i. Prescription Medications – with pick list input
    ii. Allergies
    iii. Pre-existing conditions
    iv. Current conditions
q. Blood pressure, able to indicate Palp and MAP
r. SPAO2 – Capnography
s. LOC
t. Pulse Rate, strength and regularity
u. Allow the user to set either the "within normal limits" or "not assessed" value to each defined assessment area (body part) by click of a single button

19. All examination of and treatment provided to the patient including, but not limited to:
    a. Medical control contact name and time of contact physician
    b. Patient protocol
    c. Method of contact
    d. Airway intervention
    e. Breathing intervention
    f. Circulatory intervention
    g. Intravenous intervention
    h. Input/Output therapy
    i. Provides patient weight conversion to metric for medications
    j. Call summary information, including all patient information entered
20. Data about the care providers including, but not limited to:
    a. Vehicle Number
    b. Primary attendant's (Attendant No. 1) name
    c. Attendant No. 2's name
    d. Attendant No. 3's name
    e. Attendant No. 4's name

21. Pre-hospital information including, but not limited to:
    a. Call times
    b. Scene location information, including County, zip code, response and scene
    c. Hospital Arrival Time and Departure Time
    d. Response districts
    e. Special scene conditions
22. Patient destination information including, but not limited to:
    a. Receiving hospital
    b. Transport urgency (lights and siren, routine, etc)
    c. Refusal of care by patient – Supports multiple languages
23. Odometer readings to determine distances including, but not limited to:
    a. From incident scene to patient destination
24. Software should provide for monitoring of all supplies utilized and give administration users the ability to access data through report writing tools
25. Desk Top Software – Provide the exact same interface and functionality as the mobile software with the exception of any pen-based, character recognition functionality that cannot be supported on desktop computers. This would not apply to web based programs.
26. Capability to import Life Pack 12 and/or Zoll information to EPCR software. Must have a minimum of two (2) methods to import info (i.e., Bluetooth and cable, etc).
27. It is preferable but not required, if EPCR software has the capability to import patient data from previous entries such as, Social Security Number, Drivers License, etc.
28. Provide a Continuous Quality Improvement Module

EPCR SECURITY CONTROLS

User Access and Security

The software should allow for an array of user access control and security that can vary by module and security level from no access to complete insert/delete/edit capability anywhere in the software system. The system should also provide a complete audit trail of every transaction or modification executed by each user.

The software should require a valid logon ID and possess two levels of security with different password levels. One is to be used for system administration and configuration and the other for field personnel.

The system should also include but not be limited to:

A. Have a hierarchy of security (logon, record, field, function, object, and user-group) to allow or prevent specified users (or groups of users) to access specified programs at specified levels of data entry, editing, updating, deleting and reporting functions.
B. Restrict download of confidential data to high-level security authorized users to prevent loss/misuse of confidential data and information.

C. Log off users after specified number of unsuccessful log on attempts and display message for user to contact the system administrator.
D. Allow specified intervals for mandatory password changes.

DATA ENTRY DEVICES

The COA and the Contractor understand and agree that the Contractor shall make available data entry devices (hand-held devices, tablet pc's and/or acceptable other data entry devices for the collection and/or transmission of medical information). The Contractor shall provide these devices, software, and all other hardware, software, and associated services and maintenance/upgrades at no additional cost to the COA. If the COA damages the hardware, the COA will only be charged actual cost to repair or replace the item. Normal wear and tear is excluded. The contractor shall provide a minimum of four (4) devices to the City for use.

Current data entry device being used by the City of Allen Fire Department is the Panasonic Toughbook CF-19RDRCG1M 10.4 LED Tablet PC. It is the desired by the City of Allen Fire Department to utilize the same/equivalent equipment or better.

SECTION VI
PROPOSAL CONTENT & EVALUATION CRITERIA

EVALUATION PROCESS

The objective of this evaluation process is to identify and select the proposer with the best satisfies the requirements of the City of Allen. All proposals received by the submission deadline will be evaluated by the City of Allen evaluation committee. The evaluation committee will review, rate, and rank each proposer's proposal in accordance with the weighted criteria contained in this document.

The City reserves the right to conduct presentations/interviews with proposers.

There are a total of 100 possible points for this proposal.

Price (Percentage of Collections) 25 points
Points are calculated using the formula below:
Lowest Bid / Other Bid x Available Points (25) = Bidder's Price Score

Experience and Client History 25 points
(Company Overview, Company Operational Information, Client History)

Proposal of Services 50 points
(Transition Plan, Hardware/Software Solution, Reporting, Billing, Collection and Customer Service Processes)

PROPOSAL RESPONSE DOCUMENTS

In order to be considered responsive, the Bidder shall submit with their Bid Proposal, such documentation as is necessary or required to attest to the company's capabilities and qualifications to perform the work as specified and all aspects of this contract in a competent and expeditious manner. Such documentation shall consist of no less than the following:

Company Overview
Respondent shall provide the following information with their submission, including a brief company overview, history, and financial status:

Firm name, address, phone number, and date established

Address and location of the local responsible office

Name of office principals, their experience and professional qualifications

Describe your firm's experience in providing EMS billing and collection services including the number of years your firm has actively participated in EMS billing and collection.

Number of company employees – internationally, nationally and locally

Describe your firm's annual employee attrition rate for the past three (3) years

Supply a list of employees who will be devoted to servicing the City's account. Individual resumes of the lead members of your service team should be supplied.

Provide a complete and current listing of all industry certifications, accreditations and affiliations your firm holds.

Describe your firm's business continuity plan.

List all audits involving your firm (or any firm previously affiliated with your firm) performed by an independent accounting agency in the past five (5) years.

Company Operational Information
Provide information regarding internal audit processes for internal procedures and compliance with all federal, state and local regulations and laws. This should include information for company processes that ensure compliance with current allowable rates of Medicare, Medicaid and all insurance providers.

Provide copy of proof of process engagement for SAS 70 Type II Certification.

Provide proof of compliance program that meets or exceeds the Department of Health and Human Services Office of Inspector General Compliance Program Guidance for Third-Party Medical Billing Companies.

Provide a copy of company's Red Flag Rules compliance plan.

Describe process improvement methodologies and ongoing training (for both company staff and the City)

Provide process to measure vendor performance, including your expected performance goals in areas such as, collection rates, data availability, customer response times, etc.

Client History
List all client cities for which your firm (or any firm previously affiliated with your firm) provides service of similar scope and size that have been audited in the past five (5) years by a governmental agency and the final outcome of said audits.

List all cities in the past three (3) years of similar scope and size that your firm no longer provides service for and a contact person for each entity.

Describe whether your firm (or any firm previously affiliated with your firm) has ever undergone an investigation by an outside agency pursuant to the filing of Medicare/Medicaid claims and describe the outcome of the investigation including ramifications to your firm or your firm's client cities.

Describe whether your firm has ever lost an account due to concerns of improper billing practices, accusations or clients concerns of fraud as defined by CMS and other applicable Federal or State Authorities.

Transition Plan
Please provide your proposed transition plan to a new billing provider. Please include proposed timeline schedule, from date of City award to complete delivery and implementation of all system components, to include but not limited to all hardware, software, and City staff training.

Hardware and Software Solution
Discuss the proposed hardware, software, and wireless system solutions to be used for servicing all aspects of this contract. Bidder is solely responsible for insuring appropriateness of use and obtaining licenses for use of proprietary software.

Responses should also include:

- Describe company's data plan to include areas of security, information availability, data storage and redundancy and an emergency recovery plan
- Proposed plan for hardware repair/replacement (to include proposed process and timeframe)
- Provide information on your Company's plan to ensure the proposed hardware will continue to meet the technical demands required throughout the life of the contract.

Reporting Processes
Provide a detailed plan which addresses the following:

- Process for operational reporting (including media format, types and frequency of reports)
- Provide information on available canned reports and sample reports
- Process for individual account reports, and customized reports on an as needed basis. The vendor flexibility and timeliness to develop customized reports will be considered in evaluating the proposal.
- Process for handling of HIPPA regulated information
- Process for reporting requirements to outside agencies, including but not limited to the Texas Trauma Registry and the Texas Department of State Health Services.

Billing Processes
Provide information for the following:

- Describe process to bill, collect and audit in compliance with all federal, state and local regulations; including internal controls and "checks and balances" process that has been implemented to ensure proper billing compliance on an ongoing basis with all applicable regulations.
- Process for gathering missing transport information (client or insurance)
- Process for billing mileage
- Process for reporting on billing and collections
- Process for re-filing of rejected claims

Collection & Customer Service Processes
Provide a detailed collection solution which addresses the following:

- Process for identification and collection of delinquent accounts which reflect the City's collection philosophy (stated on page 14, Allen Fire Department Background)
- Company's collection process. Please provide dialogs, scripts, forms or letters. Please highlight any aspects of your company's collections capabilities that distinguish it from other firms offering the same or similar services.
- Process for reporting uncollected/delinquent accounts

- Process to provide multiple payment methods to customers and a description of all available options
- Process for handling customer inquiries through multiple media (email, telephone, written), including response times, performance measurements and goals.
- Process which allows the customer to view their account
- Process for maintaining and keeping active all certifications required such as Medicare and Medicaid on behalf of the City of Allen.
- Explain for customer service process for City of Allen staff. Provide contact information, hours of operation, expected turnaround time for problem resolution.

SECTION VII
PRICING

Vendors should submit one original pricing sheet.

This pricing sheet should be submitted in a sealed envelope separate from the proposal documents. Please print Company Name, 2017-1-37 Pricing Sheet on the outside of your envelope. You must submit this sheet at the time you submit your proposal, your proposal will be non-responsive without this information.

Do not include this information in the requested proposal copies.

DESCRIPTION	**COMMISSION RATE BASED ON COLLECTIONS** **Percentage of collections to be Paid to Vendor**
Commission Rate – Billing for EMS Services	**%**

COMPANY NAME: _____

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **TITLE:** _____

EXHIBIT "B"
RFP RESPONSE

BID ENDORSEMENT

The undersigned, in submitting this bid proposal and their endorsement of same, represents that they are authorized to obligate their firm, that they have read this entire bid proposal package, is aware of the covenants contained herein and will abide by and adhere to the expressed requirements.

Submittals will be considered as being responsive only if entire Bid Package plus any/all attachments is returned with all blanks filled in.

SUBMITTED BY:

Advanced Data Processing, Inc., a subsidiary of Intermedix Corporation

(OFFICIAL Firm Name)

By: _____

(Original Signature) **Must be signed to be considered responsive**

Michael Wallace

(Typed or Printed Name)

Chief Financial Officer 2/21/17

(Title) (Date)

Remittance Address: 6451 N. Federal Highway, Suite 1000

Fort Lauderdale, FL 33308

(Zip Code)

Phone #: (954) 308-8700

Fax #: (954) 308-8725

E-Mail Address: Jackie.Willett@intermedix.com

If an addendum is issued for this bid, please acknowledge receipt.

ADDENDUMS/AMENDMENTS:

1) 2/17/17 date acknowledged
2) _____ date acknowledged
3) _____ date acknowledged

intermedix

Request for Proposal for Emergency Medical (EMS) Billing and Collection Services

#2017-1-37

February 23, 2017 @ 2:00 P.M. Central Time

Jackie Willett
Senior Vice President

Intermedix Corporation
78 Regency Parkway
Mansfield, TX 76063

817.539.3009 | Jackie.Willett@intermedix.com

Rosanne Lemus, CPPB
Buyer

City of Allen
Purchasing Department
305 Century Parkway
Allen, TX 75013

214.509.4633 | rlemus@cityofallen.org

intermedix

February 21, 2017

Ms. Rosanne Lemus, CPPB, Buyer
City of Allen Purchasing Division
305 Century Parkway
Allen, TX 75013

Dear Ms. Lemus,

Attached is the Intermedix proposal for Emergency Medical (EMS) Billing and Collection Services for the City of Allen. We are proud to have worked closely with the City of Allen to establish a foundation for the compliant billing and collections. To date, we have reached some significant milestones together including:

- Relationships with hospitals that receive the City's patient transports includes electronic connections with Baylor Hospital Plano, Children's Legacy Hospital, Children's Medical Center Dallas, Heart Hospital at Baylor Plano, etc., and are working with hospital IT contacts at your other top receiving facilities.
- Year-to-date collections of $1,311,378.06.
- Provision of emergency response billing for Fire Department services, which we will continue to support if selected as your EMS transport billing vendor.

In addition to these past successes, Intermedix is committed to focusing on the future and will continue to bring opportunities to the City including:

- Guidance on supplemental funding sources without unrealistic expectations (e.g., supplemental Medicaid dollars).
- We will deploy our strong partnership with PCG, which consists of 37 mutual clients who we have helped maximize their supplemental billing program.
- Review of market and industry changes and what changes Intermedix and/or the City can make to best deal with those changes (e.g., creative ways to approach the increase in high deductible insurance plans).
- How to drive incremental improvements to influence revenue such as feedback on documentation, training resources, statement experimentation, and alternative approaches to working with insurance carriers.

We are confident that our direct experience with the City and our industry leadership are a clear advantage to the future of the City's EMS billing and collection services.

Thank you for allowing us to serve as your revenue cycle management partner over our many years working with you, and we sincerely look forward to the opportunity to continue our partnership. Please feel free to contact Jackie Willett, Senior Vice President at (817) 539-3101 or via email at Jackie.Willett@intermedix.com, should you have any questions about our response.

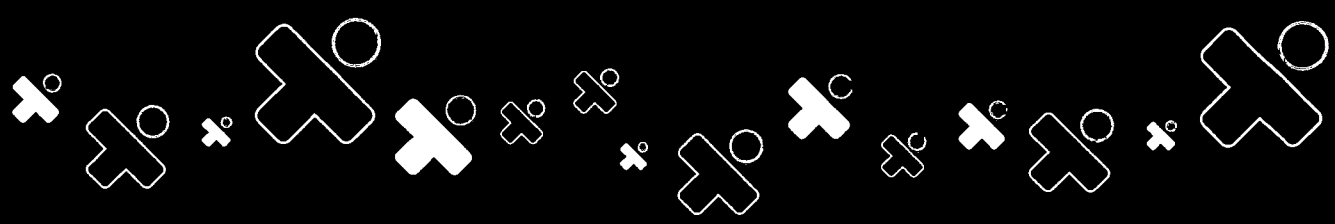
Respectfully submitted,

Michael Wallace
Chief Financial Officer

TABLE OF CONTENTS

RFP #2017-1-37

I. Executive Summary



I. EXECUTIVE SUMMARY

Intermedix is a leader in providing EMS billing and collection services and technology to municipal agencies through national experience and local expertise. The following illustrates how we make this possible and what is unique about Intermedix.

Billing Expertise

- Our proprietary billing platform, efficient workflow and industry leading professionals have produced hundreds of success stories in which we have increased collections and exceeded projections.
- We match every patient account to a database with more than 30 million patient records to find missing insurance information and improve your collections.
- Should you desire to partner with another ePCR versus TripTix, we have deep experience integrating with virtually every ePCR in the market to securely bring ePCRs into our billing system to optimize reimbursement for the City.

Patient Focus

- We act as an extension of our clients with professional and compassionate care with each patient interaction.
- We use state-of-the art technology at our Patient Contact Center that ensures efficient call processing, live translation services and delivers patient satisfaction.

National Leadership

- We have multiple, redundant operations and data storage facilities across the country to ensure business continuity in the event of a catastrophe.
- We have an elite compliance department that includes a Chief Compliance Officer and a dedicated EMS Compliance Officer.
- We are an active software company with hundreds of developers and a team dedicated to the security and effectiveness of our proprietary billing technology.
- We have representation in Washington, D.C. and recognized industry governing bodies, giving our clients a legislative voice and the opportunity to learn about new developments directly from the source to stay informed.

Partnership

In addition to optimizing your revenue through our proprietary technology and services, we are positioned to help you adapt to a changing health care environment with additional business services and technology solutions. We are more than just a billing company - we will continue to be your partner.

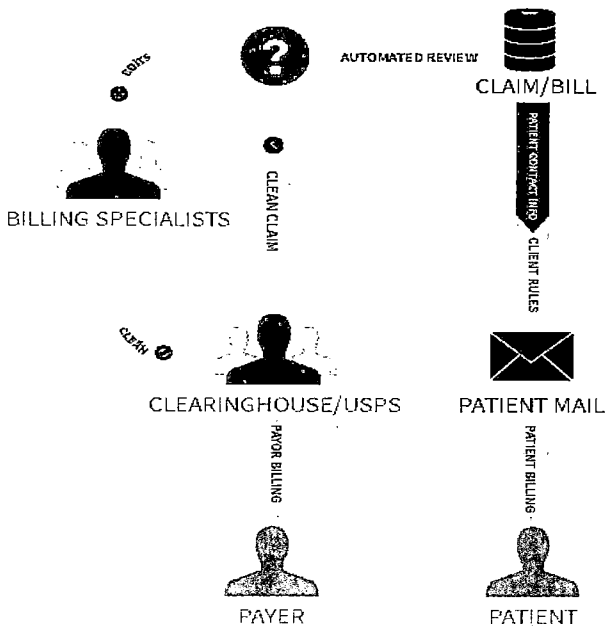
Intermedix Billing Process

As your current RCM partner, we understand that your agency has a CMS Directive and we have programmed our systems to assure we do not balance bill in District patients. As soon as the necessary patient demographic and insurance information is obtained and the account is updated, a claim can be sent out. For accounts that do not contain the necessary information to file a claim to a third party payer, the duration may be longer to ensure that all resources are exhausted to try to locate and confirm valid payer information. Any claim that has not been identified to have a third party payer will be sent out on a private-pay bill schedule within the time limits required by the City.

We use a combination of automated technology and billing specialist monitoring to ensure clean claims. The depth of our company makes it possible to communicate electronically with a large number of payers.

Billing Workflow

Our customizable patient billing rules ensure a patient-centric billing process that follows the process shown below.



Prior to submission, we automatically review claims against our proprietary rules-based engine. Claims not passing the review are placed into a work queue and processed by team members. Our clearinghouse provides a second level of review for electronic claims. Inconsistencies caught by our clearinghouse are also reviewed by a billing specialist and updated in the Intermedix system.

Claims to Medicare, Medicaid and most commercial payers are transmitted electronically. We print and mail paper claims if electronic delivery is not available or when the payer requires hard copies of PCRs or explanation of benefits.

Billing the Patient

Intermedix does extra work behind the scenes to ensure that we have gathered accurate patient contact information. We identify accounts with invalid addresses, as well as other data elements, and automatically apply our skip tracing process and implement manual research tools to find updated mailing address from our external demographic data provider, previous transports and hospital files.

Patient billing will follow the specific process designated by the City. If insurance information has not yet been captured on the account, the statement will ask that the patient provide payment or insurance information, and instructs them on how to do so.

Insurance information can be provided by the patient using the following methods:

- Returning the payment invoice with completed information on the back via regular mail
- Calling our toll-free customer service line
- Logging on to the patient portal on our website

Statement activity is generated automatically by the billing system, although authorized users can access and print statements on-demand as desired. For example, if a patient visits or calls your office requesting a copy of their statement, you can access the account and print the desired information for your patients. The patient statement wording is fully customizable to meet the needs of the City.

Intermedix has a flexible patient mail application that ensures clear and specific communication:

- We include account charge, payment and insurance information on invoices.
- We supply virtually unlimited patient statement wording variations.
- We automatically generate mail from the billing system.
- We allow authorized users to access and print statements on demand.

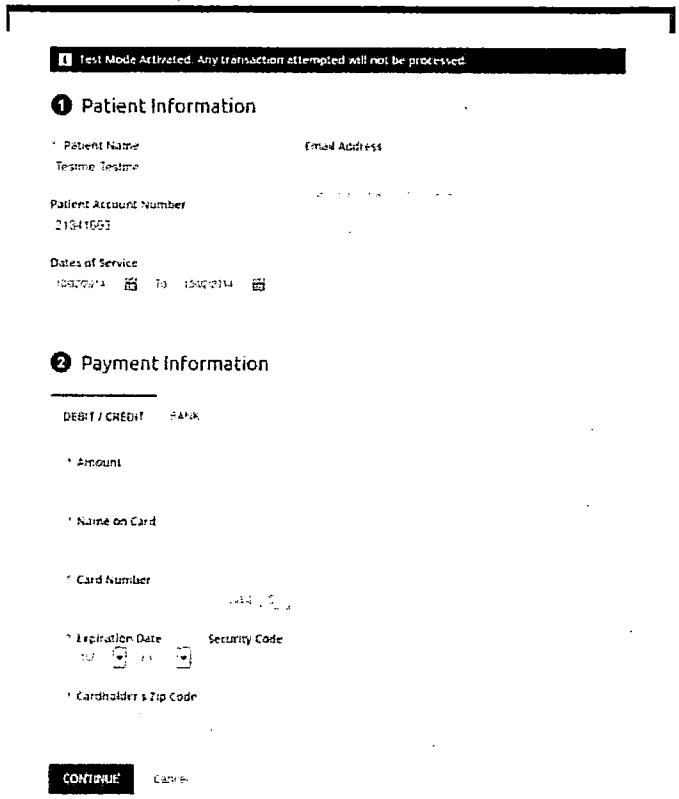
Online Patient Portal with Payment Options

Average clean claim rate = **94%**

First invoice payment rate = **80%**

Claims submitted electronically = **100%***

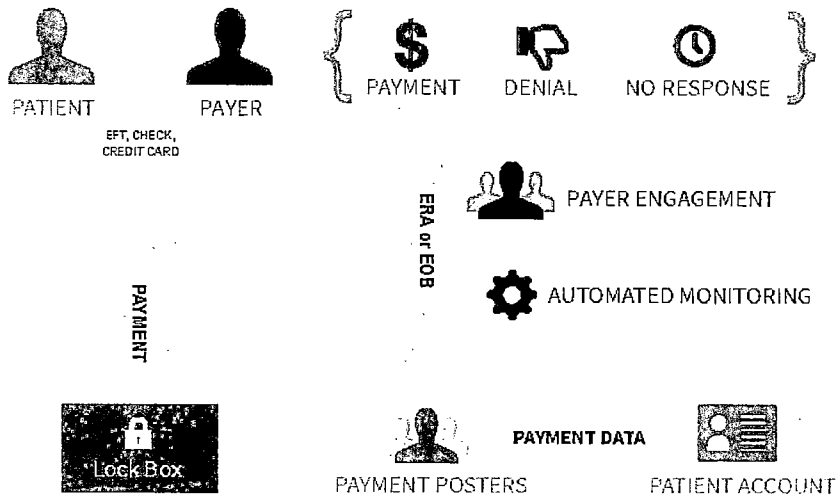
*(*to payers who accept electronic submission)*



Payer Response

Payer responses can vary significantly between the different pay classes. Medicare will typically respond within one to two weeks from claims filing, with Medicaid typically responding between two to three weeks from initial filing. Commercial insurance normally responds anywhere from two to five weeks from claims filing. We understand that the majority of patient private-pay accounts are often difficult to collect due to a lack of patient motivation. Private-pay accounts that do get paid in full are typically paid between one to seven months from PCR receipt. Therefore, we follow the process shown below for payment receipt, posting and follow-up:

Payer Response Workflow



Payment Posting

Upon receipt of payment documentation, our Payment Posters promptly post payments to the account. We provide the tools necessary to receive payments through several methods, including electronic fund transfers (EFTs), checks and credit cards. We receive electronic payment from Medicare, Medicaid and most commercial payers and our Electronic Remittance Advice (ERA) Browser allows the Payment Poster to access and verify these responses. When we receive hardcopy EOB documents instead of ERAs, a Payment Poster manually applies the payment with our web-based system. Credit card information received through the contact center or patient correspondence is processed by a Payment Poster online through Virtual Merchant.

We review every data element for accuracy and completeness before committing transactions to our database. We maintain an audit trail with the User ID to ensure the best quality assurance processes. If payments are received without identifying information, they appear in our Check Reconciliation Queue for follow-up.

We can provide monthly reconciliation with your bank account.

Supplemental Payer Claims Filing

Claims that contain supplemental payer information are submitted according to the established procedures after the initial payment is received. Once a response has been received from the primary payer, or supplemental information provided from a patient directing us to a viable payment source, we automatically update the system, re-categorize the claim and submit to the appropriate payer.

When dealing with Medicare crossover claims:

- We send claims to the supplemental insurer automatically.
- We automatically file a claim with the corresponding EOBs to the secondary payer on file if a secondary payment is not received in a predefined number of days.
- We automatically handle exceptions and adjust the remaining balance when Medicaid does not cover the remaining 20% responsibility.
- We file a claim with the supplemental insurer immediately upon receipt of Medicare's Electronic Remittance Advice when we have supplemental insurance (MediGap) on file, but Medicare has not crossed over the information to the payer.
- We file Medicare secondary claims electronically with all required information.

Denial Management

Our goal is to file a clean claim the first time; however, denials do occur. In case of a denial, we initiate a series of actions specific to the denial reason. For example:

- If a claim is denied due to a policy number issue, we check a number of insurance eligibility sources and may contact the patient to obtain the correct insurance information.
- If a claim is denied for medical necessity reasons, we review the PCR to verify the original medical necessity determination.

Our denial rate is **6.4%,** and this includes denials for any reason.

Approximately **80%** of denials are related to coverage issues and about **15%** are related to short pay appeals to commercial payers.

We are committed to timely and accurate processing to improve cash flow, and address many denials automatically upon receipt. We are continuously expanding the payer and denial code combinations that can be handled automatically. Denials that are not processed automatically are addressed by Accounts Receivable resources through our Manual Denial Management Queue.

We engage in a number of activities to resolve accounts such as researching accounts, verifying electronic claim status, accessing payer websites and making payer phone calls. Once the problem has been identified, we update accounts and re-file claims when

appropriate. The queue allows sorting by payer, so that our representatives can quickly resolve multiple claim issues for a single payer at the same time.

Short Pays

We appeal short pays in which the carrier will accept an appeal from the provider and correct any coverage related issues by re-verifying insurance with our toolbox of technological and database tools.

> Intermedix is successful on short pays approximately **35%** of the time, and we have seen a marked increase in commercial short pays over the last 24 months as payers are shifting more responsibility to the patient.

We feel very confident that when we submit a transport for payment to governmental payer, we have determined that it meets the rules for Medical Necessity, Level of Service, Medicare Signature Requirements, and any remaining submittal requirements. Thus, any account that would subsequently be denied is appealed. This is typically not a large volume and usually requires only a trip report being sent to the payer.

Credit card or e-check payment success rate = **$80** per uninsured account*

*(*compared to $18 for clients who do not offer online payment options)*

Primary claims filed = **55,000** per week

Monthly inbound calls = **55,600** calls

Average speed to answer = **17** seconds

Patient Response

We offer a number of methods for the patient or patient representative to respond to requests for insurance or payment. For example, they can contact us by mail, through a customer service toll-free phone line or on our secure patient website. We recommend that clients use an online payment solution to significantly increase collections.

Our professionally staffed Patient Contact Center is focused solely on interacting with EMS transport patients. Our representatives handle both insurance and private-pay arrangements. Patients can use a toll-free number to access the Contact Center, which takes calls between 8:00 a.m. and 7:00 p.m. Central Time. The Contact Center uses the latest telephony technology, including skills-based routing by call type and language preferences.

We have a number of bilingual Contact Center representatives for foreign language calls with fluency in many languages including Spanish, Chinese Dialects, French, Creole and others. Translation services are also available where patient account representatives can dial in the vendor for a live conference with a translator for one of the 200+ supported languages.

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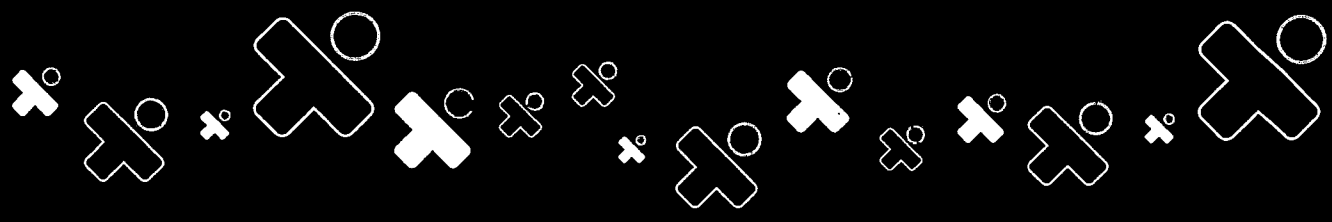
II. Company Overview



II. COMPANY OVERVIEW

Respondent shall provide the following information with their submission, including a brief company overview, history, and financial status:

Intermedix has operated continuously for 38 years performing EMS billing. Today, we serve more than 300 clients across the country and many of the largest agencies in the United States. We also have significant experience in Texas, processing more than 200,000 annual transports for 89 EMS clients. Nationally, we process over 4 million claims per year, which is more than double the amount of our nearest competitor. We have provided our audited financial statements within Section XI.

Firm name, address, phone number, and date established

Advanced Data Processing, Inc., a subsidiary of Intermedix Corporation

Headquarters location

6451 North Federal Highway, Suite 1000
Fort Lauderdale, FL 33308
Phone: 954-308-8700

Date established
September 18, 2002

Address and location of the local responsible office

78 Regency Parkway
Mansfield, TX 76063

Name of office principals, their experience and professional qualifications

Leadership Team	
Joel Portice, Chief Executive Officer	Joel Portice leads the Intermedix Executive team. He has more than 20 years of experience in the government, business and healthcare industries. Prior to joining Intermedix, Portice held executive management positions; he was the co-founder and former Chief Operating Officer of Enclarity and most recently, he served as Division President of Government Solutions and Corporate Strategy at HMS Holdings Corp. Portice earned his bachelor's degree in political science from the University of South Dakota and holds a master's degree in management from Hamline University.
Ken Cooke, President	Ken Cooke leads the operations across all divisions at Intermedix. He has more than 25 years of operational experience. Prior to joining Intermedix, Cooke held the position as Global and U.S. Chief Information Officer at PricewaterhouseCoopers, LLP. Cooke earned his bachelor's degree in business and economics from Marietta College and holds a master's degree in business administration from Ohio University.

Melissa Leigh, CHC, Chief Compliance Officer	Melissa Leigh served as the company's Associate General Counsel for three years before being appointed Chief Compliance Officer of Intermedix in 2015. In her role as CCO, she is responsible for the enterprise-wide compliance program. As an attorney, Leigh brings a wealth of organizational knowledge and industry expertise to provide legal and regulatory guidance. Leigh holds a bachelor's degree from Colgate University, her masters from New York University and her Juris Doctorate from the Pace University School of Law.
Michael Wallace, Chief Financial Officer	Michael Wallace oversees Intermedix financial activities. He has more than 23 years of experience in finance. Prior to joining Intermedix, Wallace was the Executive Vice President and Chief Financial Officer at the Elephant Group. Wallace earned his bachelor's degree in business administration and accounting from the University of Notre Dame.

Describe your firm's experience in providing EMS billing and collection services including the number of years your firm has actively participated in EMS billing and collection.

Intermedix has had the privilege of providing EMS billing services for hundreds of clients throughout the country over the last 38 years. Today, we have more than 300 clients that have chosen to partner with us to outsource billing for the ambulance transports and related services they provide to their communities.

- El Paso Fire Department (TX) – 43,000 transports
- New Orleans EMS (LA) – 36,000 transports
- Anne Arundel County Fire Department (MD) – 38,000 transports
- Sacramento Fire Department (CA) – 40,000 transports
- Mesa Fire Medical Department (AZ) – 40,000 transports

While the expansion of our services to new clients is clear indicator of where your peer agencies are choosing to place their trust in outsourcing EMS billing services, is it probably more telling to understand that more than 20 clients have chosen to stay with Intermedix during the last thirty six months – including the cities of El Paso (TX), Watauga (TX) and Mesa (AZ). We've had several clients that have returned to partnership with Intermedix for their EMS billing services partner after a period of time away – including Cy-Fair Volunteer Fire Department in Texas.

Number of company employees – internationally, nationally and locally

Internationally: 697 employees

Nationally: 1749 employees

Locally: Living in City of Allen – 5 employees, living in Plano – 17 employees, working in our Dallas office – 117 employees (includes some previously counted in Allen and Plano, and does not include remote workers)

Describe your firm's annual employee attrition rate for the past three (3) years

2014 – 25.44%

2015 – 29.35%

2016 – 24.1%

Supply a list of employees who will be devoted to servicing the City's account. Individual resumes of the lead members of your service team should be supplied.

When it comes to managing your day-to-day business, our team of operations and client relations leaders are dedicated to serving your needs through direct EMS billing experience in the region and particularly for the City of Allen. Marie West, Client Relations Manager, will work closely with Jackie Willett, Senior Vice President to ensure that the City, the Fire Department and your patients receive accurate, effective and timely service - allowing you to focus on your daily demands.

Your Client Relations Manager, Marie West, will be available to the City for:

- Monthly reports
- Service meetings
- Revenue and performance monitoring
- Identifying trends
- Resolution of issues identified by the City, our Client Support and Operations Teams

Our team members average more than 20 years in healthcare and 10 years at Intermedix.

CLIENT RELATIONS MANGER

Marie West

- Responsible for relationship and service at the City
- Has been with Intermedix for 7 years.
- Over 15 years of experience in this industry

EMS OPERATIONS

Emily Mize, Director of Operations

- Responsible for operations procedures and processes for EMS billing clients in Texas
- More than 16 years of operations and healthcare experience

EMS EXECUTIVE LEADERSHIP

Jackie Willett, CHBME

Senior Vice President

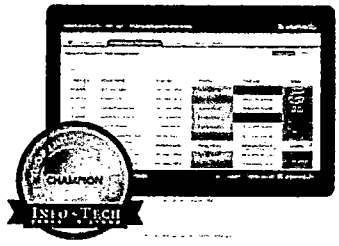
- Responsible for client management and EMS billing operations for Texas clients
- More than 20 years of experience in EMS, business and finance

Provide a complete and current listing of all industry certifications, accreditations and affiliations your firm holds.

Association	Division	Comment
American Academy of Professional Coders	EMS/ED	Corporate Member Since 2000
American Ambulance Association	EMS	Since 2003 Participant on Federal Reimbursement Task Force
Healthcare Billing and Management Association	EMS/ED	Since 1995 Charter Member, Ethics Compliance Committee, Positions held: President, Treasurer and Board Members
Healthcare Compliance Association	EMS/ED	Since 2003
HCCA Certified Healthcare Compliance	EMS	Member
SCCE Certified Compliance and Ethics Professional (CCEP)	EMS	Member
International Association of EMS Chiefs	EMS	Since 2005 Joint development with IAEMSC of the National EMS Health and Safety Surveillance System
Government Finance Officers Association	EMS	Member
NEMSIS (State Compliant Software)	EMS/Public Health	Since 2014
HFMA	EMS	Member – Current Yeager Award Committee Chair Former Board Member, Systems Committee Chair, Compliance Chair
HIMSS	EMS	Board Advisor
The American Health Information Management Association	EMS	Member
Anesthesia Administrators Assembly (MGMA)	ARM	Member
Emergency Department Practice Management Association (EDPMA)	ED	Board Member, Executive Committee, Treasurer, Member of Provide

Association	Division	Comment
		Enrollment, State Regulatory and Insurance, Documentation
Medical Group Management Association	ED	Member
We are also members of various state-related EMS associations, including but not limited to: ▪ United New York Ambulance Network ▪ Ohio Chapter Health Information Management Association ▪ Texas Medical Group Management Association, Emergency Medicine Practice Alliance, Association of Air Medical Services, Ambulance Association, EMS Alliance		

In addition to our association memberships, Intermedix has been recognized by or received:



- The Florida Preparedness Association 2017 Corporate Award
- Info-Tech Research Group Vendor Landscape Award for Intermedix' WebEOC EMS solution—exemplary status above all others reviewed
- Top 5 Revenue Cycle Management Vendor for Physician Practices
- Ragan's 2015 Employee Communications Award – Best Executive Communication

Describe your firm's business continuity plan.

Intermedix uses a documented Adverse Event Planning and Management Procedure to maintain operations during an emergency that outlines planning, management responsibilities, and actions that should be taken to prepare for, respond during and recover following an adverse event. Our highest priority is always the safety of our people. Pre-Event planning includes (i.e. a hurricane or pandemic that allows assessment prior to the occurrence of the actual event) bringing together the pre-event team to reiterate prearranged plans for maintaining communication and safety throughout the event. The Event Response Team will be immediately engaged and provide guidance prior to and during the event according to documented procedures. Post-Event response includes assessment and status updates from the Event Response Team and invocation of the Disaster Recovery Plan, if deemed necessary. A post-event action list is maintained to ensure that successes and opportunities are documented, policies are updated and any used supplies are re-stocked and ready for the next event.

List all audits involving your firm (or any firm previously affiliated with your firm) performed by an independent accounting agency in the past five (5) years.

Our company conducts business nationally with emergency medical services and physician practice clients and local, state and federal government clients and globally with respect to emergency management systems. In the United States, Intermedix serves approximately 1,000 customers. Given the scope and nature of its business operations, Intermedix is sometimes subject to or named in complaints in litigation or arbitration matters in the ordinary course of its business. Intermedix represents that no pending legal matters, either individually or in the aggregate, are material or would create an impediment to Intermedix's ability to perform its services.

Bidder Qualifications

1. **Each respondent to this proposal shall be capable of meeting the following minimum requirements:**

   We have provided our responses to the following qualifications within our proposal.

2. **The Contractor shall be equipped with computer operations to receive and send data electronically. Facsimile transmissions and mail or courier services shall be held to a minimum.**

   We meet this requirement.

3. **The Contractor shall possess and maintain nationwide billing and collection capabilities.**

   We meet this requirement.

4. **The Contractor shall have and maintain a trained staff with experience working with Medicare, Medicaid, Worker's Compensation, Tricare and commercial insurance companies, as well as individual debtors.**

   We meet this requirement.

5. **The Contractor will maintain compliance with the Health Information Privacy and Portability Act (HIPPA), as amended.**

   We meet this requirement.

6. **The Contractor shall have an internal audit processes for internal procedures and compliance with all federal, state and local regulations and laws.**

   We meet this requirement.

7. **A process to provide and maintain a data base or data warehouse of accessible information for all billing and collection information. This data base or data warehouse must be accessible by designated City employees via the web for the purpose of identifying and retrieving information in a variety of report formats.**

We meet this requirement.

8. **The Contractor shall have a detailed Data Plan which addresses issues of security, information availability, data storage and duplication, and an emergency recovery plan.**

   We meet this requirement.

9. **The Contractor shall have the ability to maintain records of all services performed and all financial transactions for each ambulance run.**

   We meet this requirement.

10. **Respondents shall at a minimum, be in the process of completing a Statement of Auditing Standards (SAS) 70 Type II certification which demonstrates an unqualified opinion, as recognized by the American Institute of Certified Public Accountants (AICPA) at the time of contract award.** ***A copy of the proof of process engagement or a copy of a previously completed audit must be submitted with the proposal. If submitting proof of process engagement, a complete report including management comments shall be submitted to the City of Allen when completed.***

    We meet this requirement.

11. **A compliance program in place that meets or exceeds the Department of Health and Human Services Office of Inspector General (OIG) Compliance Program Guidance for Third-Party Medical Billing Companies.** ***A copy of the service agency's program shall be submitted with the proposal.***

    We meet this requirement.

12. **A program that is fully compliant with the Federal Trade Commission's Red Flag Rules and must provide the City with all updates throughout the term of the contract.** ***A copy of the service agency's Red Flag Rules compliance plan shall be submitted with the proposal.***

    We meet this requirement.

13. **The ability to gather, extract, and transmit data collected from patient run information to satisfy the reporting requirements the Allen Fire Department has to all outside agencies including but not limited to the Texas Trauma Registry and the Texas Department of State Health Services.**

    We meet this requirement.

14. **The contractor shall have a process to keep current with the allowable rates of Medicare, Medicaid and all insurance providers.**

    We meet this requirement.

15. **The contractor shall have a process to maintain and keep active any and all certifications required such as, Medicare and Medicaid on the behalf of City of Allen.**

    We meet this requirement.

16. **The contractor shall provide electronic patient care report (EPCR) software and hardware for City use. Please see Section V, Technical Specifications, for technical specifications on EPCR software and hardware.**

    We meet this requirement.

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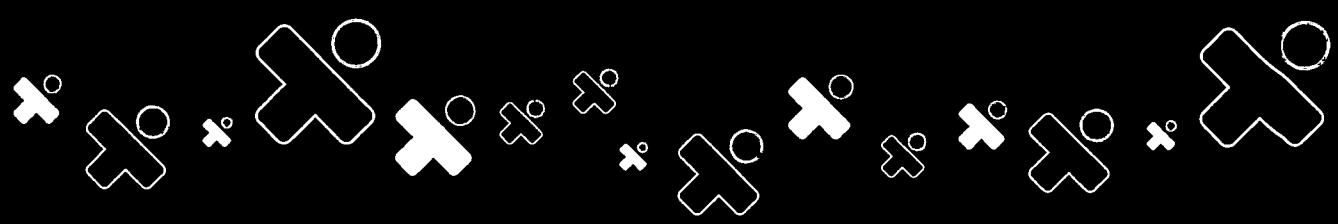
III. Company Operational Information



III. COMPANY OPERATIONAL INFORMATION

Provide information regarding internal audit processes for internal procedures and compliance with all federal, state and local regulations and laws. This should include information for company processes that ensure compliance with current allowable rates of Medicare, Medicaid and all insurance providers.

We undergo a rigorous SSAE 16 (Statements on Standards for Attestation Engagements No. 16) audit every year. Prior to 2011, Intermedix provided an annual audit by an independent auditing firm to achieve and maintain SAS 70 Type II compliance, which evaluates a series of objectives within the company. In recent years, our company has gone even further in our commitment to quality by completing the SSAE 16 audit. SSAE 16 is the next generation of AICPA auditing standards for reporting on controls at service organizations (including datacenters) in the United States.

SSAE 16 goes beyond the SAS 70 by requiring the auditor to obtain a written assertion from management regarding the design and operating effectiveness of the controls being reviewed. SSAE 16 also provides better alignment with the international audit standard ISAE 3402.

Provide copy of proof of process engagement for SAS 70 Type II Certification.

Please see *Section XI. Forms and Attachments* for a copy of our certification.

Provide proof of compliance program that meets or exceeds the Department of Health and Human Services Office of Inspector General Compliance Program Guidance for Third-Party Medical Billing Companies.

Intermedix has a keen focus on the many laws and regulations that impact the industry, including interpretation changes communicated by CMS. We have a dedicated EMS Compliance Officer who ensures our compliance, monitors audits and findings and is proactively engaged in helping to shape the future of the industry. All Intermedix employees go through HIPAA and compliance training upon hire and then annually thereafter. The use and release of patient information is front and center of our Compliance Program.

Intermedix and its systems are certified compliant with CMS rules and regulations, including HIPAA and HITECH requirements. Our compliance program is dedicated to HIPAA compliance, encompassing HIPAA privacy and security rules, HITECH and the Omnibus Rule. Our program also addresses PCI (Payment Card Industry) Data Security Standards and applicable State Information Security and Privacy controls.

The Intermedix Security and Compliance program has been in place since 2002 and is continuously improved. In addition to the necessary policies, procedures and employee training, new measures are routinely implemented to meet or exceed current regulatory requirements. Our Compliance Program includes a formal plan as well as a code of conduct and conflict of interest policy to help ensure adherence to current Federal HIPAA and HIPAA HITECH guidelines relating to privacy of patient records. All Intermedix systems employ segregation of duties to help ensure that only those employees that need access to PHI

receive it to comply with HIPAA requirements of security, privacy, and data transmission. All employees receive compliance education, standards of conduct training and HIPAA privacy requirements overview upon hire and receive ongoing training throughout their employment.

Beyond compliance, we also feel it is important track the broader changes in the health care industry. As the health care landscape continues to change, we expect that it may take many years yet to realize the full impact of reform on health plan design, through increased demand for emergency services, varied emergency service delivery models, alternate reimbursement models and more intricate regulatory mandates. We readily accept the responsibility of providing insights into these and other issues for our clients and their crews and how they affect their day-to-day business.

Please see *Section XI. Forms and Attachments* for additional information.

Provide a copy of company's Red Flag Rules compliance plan.

Please see *Section XI. Forms and Attachments* for more information on our Red Flag Rules compliance plan.

Describe process improvement methodologies and ongoing training (for both company staff and the City)

We customarily provide training for field personnel on the essential elements of clinical, patient demographic and insurance information that helps maximize reimbursements when properly collected. We also offer the Intermedix Training Center, an online, virtual classroom where our clients and their staff can access many training topics that are designed to help improve the patient care reports for 911 providers. The training center is accessible 24/7/365 via the web.

Provide process to measure vendor performance, including your expected performance goals in areas such as, collection rates, data availability, customer response times, etc.

Our Quality Assurance Plan includes consistent monitoring, documentation and review of the processes we employ to accurately and compliantly bill for EMS transports. We examine measurable coding standards as well as quality metrics, including the correctness of tasks for a particular denial type. We also monitor billing cycle times and provide reports for our clients. We have included details about our quality assurance and internal auditing program to include automated system controls, coder audits, implementation and ePCR integration controls.

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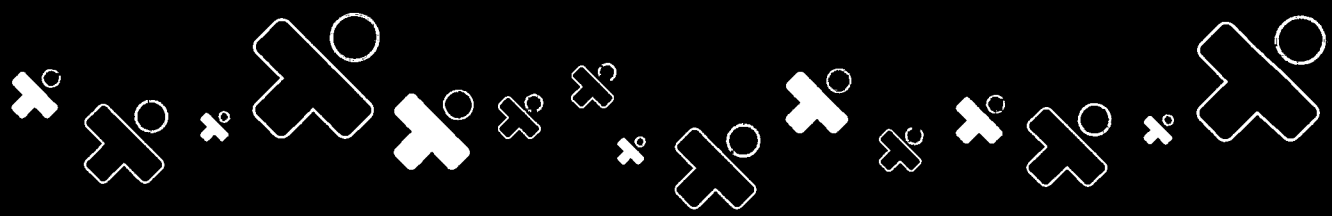
IV. Client History



IV. CLIENT HISTORY

List all client cities for which your firm (or any firm previously affiliated with your firm) provides service of similar scope and size that have been audited in the past five (5) years by a governmental agency and the final outcome of said audits.

To the best of our knowledge, we have not been audited by a governmental agency in the past five years.

List all cities in the past three (3) years of similar scope and size that your firm no longer provides service for and a contact person for each entity.

Cy-Fair

Contact Name: Chief Amy Ramon

Phone: 281-656-3402

Georgetown Fire Department

Contact Name: John Sullivan, Fire Chief

Phone: 512-930-3611

Describe whether your firm (or any firm previously affiliated with your firm) has ever undergone an investigation by an outside agency pursuant to the filing of Medicare/Medicaid claims and describe the outcome of the investigation including ramifications to your firm or your firm's client cities.

To the best of our knowledge, no.

Describe whether your firm has ever lost an account due to concerns of improper billing practices, accusations or clients concerns of fraud as defined by CMS and other applicable Federal or State Authorities.

To the best of our knowledge, no.

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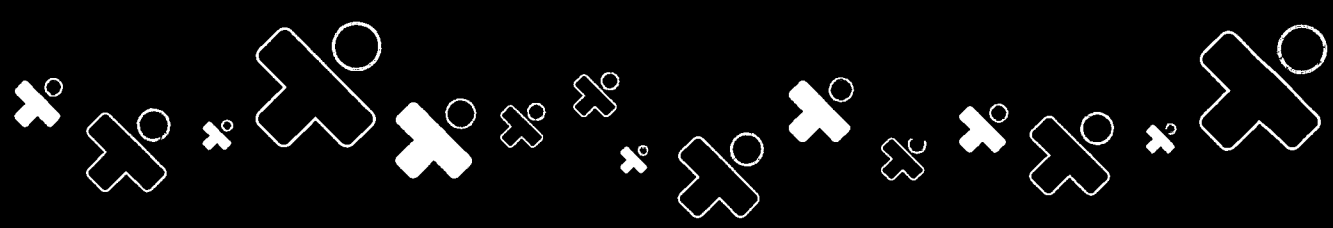
V. Transition Plan



V. TRANSITION PLAN

Please provide your proposed transition plan to a new billing provider. Please include proposed timeline schedule, from date of City award to complete delivery and implementation of all system components, to include but not limited to all hardware, software, and City staff training.

Our team is dedicated to the City of Allen and has developed immeasurable organizational knowledge and experience over the years, regarding Texas payers, relationships with your receiving facilities, unique technology integrations, and your policies and procedures. Because this knowledge base is already in place, a new vendor would face a significant learning curve to reach the current depth of our partnership with the City. Even if another vendor tries to create a way to mitigate cash flow impacts, they will be unable to interface with your systems and financial reporting processes to avoid impacting data flows to the City. Choosing Intermedix is the only choice for the City that will avoid hundreds of hours of implementation and integration investment, while mitigating the revenue risk of transition to **zero**.

Intermedix has consistently increased revenue for the City throughout our relationship, while working very closely with the City to ensure its needs are being met every step of the way.

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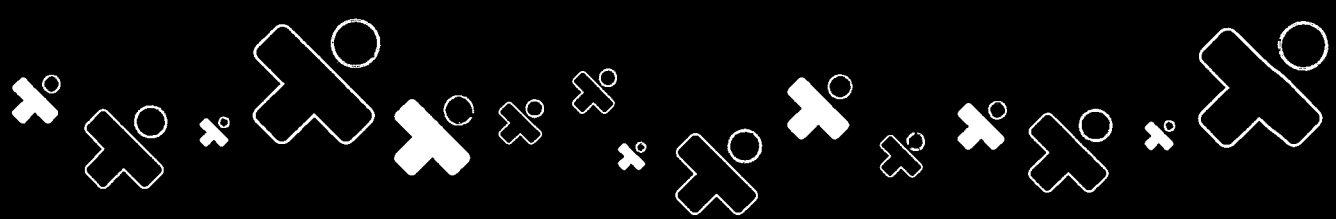
VI. Hardware and Software Solution



VI. HARDWARE AND SOFTWARE SOLUTION

Discuss the proposed hardware, software, and wireless system solutions to be used for servicing all aspects of this contract. Bidder is solely responsible for insuring appropriateness of use and obtaining licenses for use of proprietary software.

Our billing system is a hosted solution, accessible with security authentication from any computer with an internet connection, 24/7/365 (excluding scheduled maintenance windows).

Responses should also include:

- **Describe company's data plan to include areas of security, information availability, data storage and redundancy and an emergency recovery plan**

  The Intermedix billing system database is backed up nightly to both disk and tape in the primary facility and disk in the secondary facility. In addition to these backups, the database is replicated in near real-time between two (2) data centers. These multiple levels of redundancy to ensure the system can be restored even after a significant disaster recovery (DR) event. We have a formal Disaster Recovery Plan (DRP) that is updated regularly and is reviewed as part of our SSAE-16 audit. The DRP plan includes procedures for restoration of service should a DR event occur. We are happy to share our DR plan with confidentially upon request. Our billing system is hosted at a state of the art third party co-location facility in Pittsburgh, Pennsylvania. Physical access is restricted to authorized personnel, and is staffed 24 hours a day, 365 days a year. Access to the facility is secured with video surveillance, biometric security, and/or as proximity card systems. The facility is protected by fire detection and suppression controls and multiple air conditioning systems. Our secondary co-location facility is located in Oklahoma City, Oklahoma. Critical billing, clinical and scanned image data is redundantly stored at both sites.

  Client access to the Intermedix billing system is provided via a web interface, using SSL/TLS. All non-web traffic between data centers and between Intermedix offices and data centers is encrypted via LAN-to-LAN IPsec tunnels via our firewall appliances.

  Each data center has multiple database servers and web application servers. Both data centers are audited annually and have received SSAE-16 Type I and II audits as recently as 2016, and have active Service Level Agreements in place for uptime. In addition, our Information Security and/or Infrastructure Teams perform walkthroughs of the facilities on a regular basis.

- **Proposed plan for hardware repair/replacement (to include proposed process and timeframe)**

  Not applicable.

- **Provide information on your Company's plan to ensure the proposed hardware will continue to meet the technical demands required throughout the life of the contract.**

  As our solution is web-hosted and enabled, we remain constantly up-to-date on technical demands.

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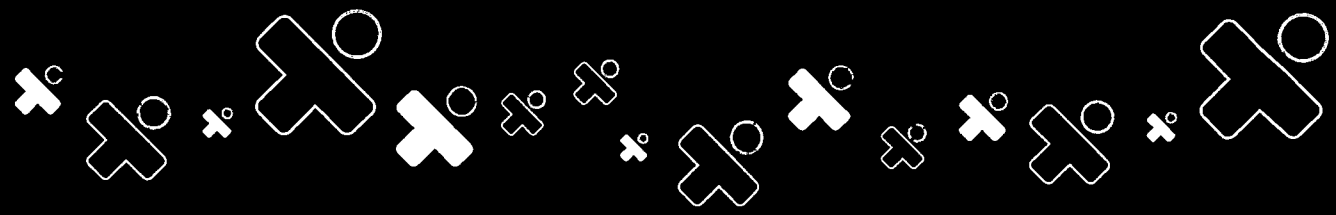
VII. Reporting Processes



VII. REPORTING PROCESSES

Provide a detailed plan which addresses the following:

- **Process for operational reporting (including media format, types and frequency of reports)**

  Intermedix offers a library of reports that have been developed specifically for EMS agencies to gain meaningful insight into the effectiveness of their billing operations. Our standard library of EMS reports includes an array of financial data reports as well as medic statistics and key performance indicators.

  We provide training on the reporting system during implementation to ensure that administrators know how to access the reports required for their agency. Reports can be scheduled to run on a regular basis, or run on-demand by the client through any internet-enabled computer.

  Please see the following pages for screenshots and examples of our standard reports.

- **Provide information on available canned reports and sample reports**

  Please see the following pages.

- **Process for individual account reports, and customized reports on an as needed basis. The vendor flexibility and timeliness to develop customized reports will be considered in evaluating the proposal.**

  The City can contact our client support team to build adhoc reports that are outside the scope of our standard reporting package. There are no extra charges for custom reporting.

- **Process for handling of HIPPA regulated information**

  We ensure continued compliance with HIPAA and the many regulations that govern the treatment of healthcare information through our dedicated compliance department which is charged with continuously monitoring changes as regulations evolve.

  Intermedix has invested in the people, policies and processes that incorporate industry best practices for ensuring compliance to the stringent rules and regulations that govern EMS billing. We have an in-house compliance department that includes a Chief Compliance Officer, an EMS Compliance Officer, an Information Security Officer, compliance auditors and security engineers who work together to ensure that our organization is focused on maintaining a culture of compliance.

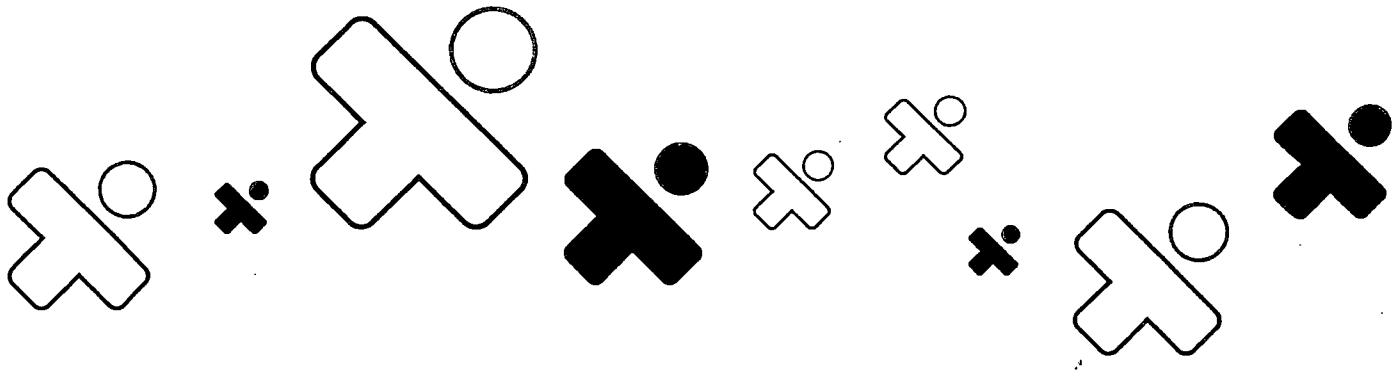
- **Process for reporting requirements to outside agencies, including but not limited to the Texas Trauma Registry and the Texas Department of State Health Services.**

  We currently meet this requirement.

intermedix

EMS Reporting Samples

Following are a few of the most commonly requested reports by our EMS clients to gain meaningful insight into the effectiveness of their billing program.



End of Month Financial Close

EMS Billing
Collection Report - By Financial Class
Period: 09/01/2015 to 9/30/2015
REPORT #1

Insurance Classification	
Transports	
Auto Insurance	
Medicaid	
Medicare	
Private Insurance	
Self Pay	
Work Comp	
Collection Accounts	
SUB-TOTAL	
Insurance Classification	
Non Transports	
Collection Accounts	
SUB-TOTAL	
Unidentified Payments	
Refunds	
NET TOTAL	

EMS Billing
Management Summary Report
Report as of: 9/30/2015
REPORT #3

ACCOUNT BALANCE PRIOR TO 9/1/15	
BILLING ACTIVITIES	
Accounts billed in September-2015	
COLLECTION (PAYMENTS)	
Payments in September-2015	
Unidentified Payments	
Refunds	
ACCOUNTS RETURNED FOR CANCELLATION	
Account Closed	
Account Closed - Charge Off	
Account Closed - In District	
Account Closed - Other	
Unfreeze / Undose	
Adjustment/Assignment - Other Reduction	
Adjustment/Assignment - Primary Insurance	
Adjustment/Assignment - Secondary Insurance	
ACCOUNT BALANCE AS OF 09/30/2015	

EMS Billing
Billing Activity Summary Report
For the month ended: 9/30/2015
REPORT #2

		AMOUNT		
Financial Class		**Current**	**Fiscal YTD**	
Auto Insurance		$1,545.00	$24,210.00	4%
Contract		$0.00	$0.00	
Medicaid		$21,165.00	$191,420.00	32%
Medicare		$12,645.00	$144,495.00	24%
Private Insurance		$14,970.00	$118,600.00	20%
Unknown		$9,330.00	$118,925.00	20%
Workers Comp		$0.00	$3,150.00	1%
TOTAL BILLABLE		**$59,655.00**	**$600,800.00**	**100%**
BILLABLE TRANSPORTS				
Emergency	BLS	$59,655.00	$598,675.00	100%
		$59,655.00	**$598,675.00**	**100%**
Non-Emergency	BLS	$0.00	$1,345.00	100%
		$0.00	**$1,345.00**	**100%**
	None	$0.00	$780.00	100%
		$0.00	**$780.00**	**100%**
	SUBTOTAL	**$59,655.00**	**$600,800.00**	**100%**
BILLABLE NON-TRANSPORT				
		$0.00	$0.00	
	SUBTOTAL	**$0.00**	**$0.00**	
NON-BILLABLE ACCOUNTS				
Voided		($860.00)	($4,690.00)	
TOTAL NON-BILLABLE		**($860.00)**	**($4,690.00)**	
TOTAL ACCOUNTS CREATED		**$58,795.00**	**$596,110.00**	

EMS Billing
Accounts Receivable Aged Trial Balance
Report as of: 9/30/2015
REPORT #4

AGE	A / R Balance	Percent of A/R
CURRENT	$54,153.36	22.38%
30 DAYS	$30,953.05	12.79%
60 DAYS	$27,907.53	11.53%
90 DAYS	$34,368.10	14.20%
120 DAYS	$27,884.18	11.52%
150 DAYS	$23,650.82	9.77%
180 Days	$7,070.34	2.92%
210 Days	$35,987.62	14.87%
TOTAL	**$241,975.00**	

Ending A/R shown on Report #3 is net of unidentified payments to date in the amount of $3,741.61

Report also includes

- Collection by Financial Class Detail
- Billing Activity Summary Detail
- Management Summary Detail
- AR Aged Trial Balance Detail
- Unidentified Payments

Monthly Summary
by Date of Service

Monthly Summary by Date of Service
Start Date: 1/1/2015 – End Date: 3/31/2015

	Billable Incidents	Gross Charges	Adjustments	Net Charges	Collections	Write Off Amt	Balance Due	Avg Charge	Avg Miles
2015-01	16453	$16,827,520.00	$9,855,722.61	$6,971,797.39	$2,993,225.06	$32,504.64	$3,946,067.69	$1,022.76	2.32
2015-02	14399	$14,729,390.00	$8,832,320.93	$5,897,069.07	$2,611,534.59	$31,988.66	$3,253,545.82	$1,022.95	2.31
2015-03	16051	$16,500,990.00	$9,808,690.66	$6,692,299.34	$2,904,414.69	$25,904.39	$3,761,980.26	$1,028.04	2.31
Totals:	**46903**	**$48,057,900.00**	**$28,496,734.20**	**$19,561,165.80**	**$8,509,174.34**	**$90,397.69**	**$10,961,593.77**	**$1,024.62**	**2.31**

Fiscal Year Summary
Start Date: 1/1/2015 – End Date: 3/31/2015

	Billable Incidents	Gross Charges	Adjustments	Net Charges	Collections	Write Off Amt	Balance Due	Avg Charge	Avg Miles
2015	46903	$48,057,900.00	$28,496,734.20	$19,561,165.80	$8,509,174.34	$90,397.69	$10,961,593.77	$1,024.62	2.31
Totals:	**46903**	**$48,057,900.00**	**$28,496,734.20**	**$19,561,165.80**	**$8,509,174.34**	**$90,397.69**	**$10,961,593.77**	**$1,024.62**	**2.31**

Calendar Year Summary
Start Date: 1/1/2015 – End Date: 3/31/2015

	Billable Incidents	Gross Charges	Adjustments	Net Charges	Collections	Write Off Amt	Balance Due	Avg Charge	Avg Miles
2015	46903	$48,057,900.00	$28,496,734.20	$19,561,165.80	$8,509,174.34	$90,397.69	$10,961,593.77	$1,024.62	2.31
Totals:	**46903**	**$48,057,900.00**	**$28,496,734.20**	**$19,561,165.80**	**$8,509,174.34**	**$90,397.69**	**$10,961,593.77**	**$1,024.62**	**2.31**

Report also includes

Additional Summary Data
- Agency Name
- Vehicle ID
- Facility Name
- Pick up Zip Code
- Average Adjustments
- Average Net Charge
- Average Collection
- Gross Collection %
- Net Collection %
- Paid %

Incidents by Level of Service
- BLS-NE - # and %
- BLS-E - # and %
- ALS-NE - # and %
- ALS-E - # and %
- ALS2 - # and %
- SCT - # and %
- Rotary - # and %
- Fixed Wing - # and %
- TNT - # and %
- Other - # and %

Incidents by Financial Class
- Medicare - # and %
- Medicaid - # and %
- Commercial - # and %
- Self-Pay - # and %
- Auto - # and %
- Workers Comp - # and %
- Contract - # and %

Monthly Summary
by Pickup Zip Code

Monthly Summary by Pickup Zip Code
Start Date: 1/1/2015 – End Date: 3/31/2015

Zip Code	Billable Incidents	Gross Charges	Adjustments	Net Charges	Collections	Write Off Amt	Balance Due	Avg Charge	Avg Miles
19101	58	$57,790.00	$26,273.14	$31,516.86	$9,480.58	$0.00	$22,036.28	$996.38	1.84
19102	317	$325,680.00	$171,763.71	$153,916.29	$70,990.97	$100.20	$82,825.12	$1,027.38	1.50
19103	635	$652,460.00	$300,478.09	$351,981.91	$191,056.23	$631.48	$160,294.20	$1,027.50	1.40
19104	1976	$2,025,790.00	$1,153,599.30	$872,190.70	$401,863.19	$150.00	$470,177.51	$1,025.20	1.67
19105	4	$3,870.00	$1,684.00	$2,186.00	$246.00	$0.00	$1,940.00	$967.50	1.75
19106	403	$412,290.00	$185,728.60	$226,561.40	$101,012.26	$3,070.09	$122,479.05	$1,023.05	1.34
19107	1206	$1,231,750.00	$584,271.73	$647,478.27	$211,837.67	$2,331.45	$433,309.15	$1,021.35	1.15
19108	3	$2,950.00	$784.46	$2,165.54	$1,205.54	$0.00	$960.00	$983.33	2.00
19109	17	$17,130.00	$6,765.22	$10,364.78	$2,512.75	$0.00	$7,852.03	$1,007.65	2.35
19110	6	$5,990.00	$2,235.60	$3,754.40	$764.40	$0.00	$2,990.00	$998.33	1.50
19111	1097	$1,121,000.00	$624,764.30	$496,235.70	$217,615.88	$3,171.45	$275,448.37	$1,021.88	2.79
19112	21	$21,480.00	$6,685.11	$14,794.89	$3,747.38	$0.00	$11,047.51	$1,022.86	2.71
19113	2	$2,030.00	$1,436.10	$593.90	$593.90	$0.00	$0.00	$1,015.00	1.50

Report also includes

Additional Summary Data
- Average Adjustments
- Average Net Charge
- Average Collection
- Gross Collection %
- Net Collection %
- Paid %

Incidents by Level of Service
- BLS-NE - # and %
- BLS-E - # and %
- ALS-NE - # and %
- ALS-E - # and %
- ALS2 - # and %
- SCT - # and %
- Rotary - # and %
- Fixed Wing - # and %
- TNT - # and %
- Other - # and %

Incidents by Financial Class
- Medicare - # and %
- Medicaid - # and %
- Commercial - # and %
- Self-Pay - # and %
- Auto - # and %
- Workers Comp - # and %
- Contract - # and %

Daily Financial Summary

Daily Financial Summary: New Charges

Date: 3/9/16

Charge ID	Date	Charge Hcpcs	Charge Description	Insurance Type	Insurance Name	Trip Number	Account Number	Charge Amount
93984553	3/9/2016	A0427	ALS1 Emergency Base Rate	Medicare	Medicare - NC			$660.00
93984554	3/9/2016	A0425	ALS Emergency Mileage	Medicare	Medicare - NC			$90.00
93988852	3/9/2016	A0429	BLS Emergency Base Rate	Medicare	Medicare - NC			$575.00
93988853	3/9/2016	A0425	BLS Emergency Mileage	Medicare	Medicare - NC			$10.00
93989906	3/9/2016	A0427	ALS1 Emergency Base Rate	Unknown				$660.00
93989907	3/9/2016	A0425	ALS Emergency Mileage	Unknown				$40.00
93991722	3/9/2016	A0427	ALS1 Emergency Base Rate	Private Insurance	United Healthcare			$660.00
93991723	3/9/2016	A0425	ALS Emergency Mileage	Private Insurance	United Healthcare			$90.00
93991724	3/9/2016	A0427	ALS1 Emergency Base Rate	Unknown				$660.00
93991725	3/9/2016	A0425	ALS Emergency Mileage	Unknown				$40.00
93991726	3/9/2016	A0429	BLS Emergency Base Rate	Unknown				$575.00

Daily Financial Summary: Voided Charges

Date: 3/9/16

Charge ID	Date	Charge Hcpcs	Charge Description	Insurance Type	Insurance Name	Trip Number	Account Number	Charge Amount
92407773	3/9/2016	A0998	Treatment / No-Transport	Unknown				$250.00
93800794	3/9/2016	A0429	BLS Emergency Base Rate	Medicare	Medicare - NC			$575.00
93800795	3/9/2016	A0425	BLS Emergency Mileage	Medicare	Medicare - NC			$90.00
93800798	3/9/2016	A0427	ALS1 Emergency Base Rate	Medicare	Medicare - NC			$660.00
93800799	3/9/2016	A0425	ALS Emergency Mileage	Medicare	Medicare - NC			$10.00

Daily Financial Summary: Payments

Date: 3/9/16

Trip Number	Date of Receipt	Posting Batch ID	Incident TX ID	Transaction Type	Insurance Type	Insurance Name	Account Number	Deposit Date	Check Number	Amount
	3/10/2016	2312757		Payment to EMS - Primary Insurance	Medicare	Medicare - NC		3/9/2016	890118549	$362.66
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/5/2016	2306045		Payment to EMS - Primary Insurance	Private Insurance	Aetna		3/9/2016	816063480004936	$184.00
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$70.75
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$129.36
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$70.75
	3/10/2016	2311026		Payment to EMS - Primary Insurance	Medicare	Medicare - NC		3/9/2016	053000191697597	$129.36
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68
	3/9/2016	2311026		Payment to EMS - Primary Insurance	Medicaid	Medicaid - NC		3/9/2016	053000191697597	$124.68

Payment Posting

Payment Posting Summary
Start Deposit Date: 1/1/2015 – End Deposit Date: 3/31/2015

Deposit Month	IMX Amount	Collections Amount	CC Amount	Total
2015-01	$2,576,592.41		$78,790.87	$2,655,383.28
2015-02	$2,830,366.33		$77,490.17	$2,907,856.50
2015-03	$3,050,882.27		$73,246.34	$3,124,128.61
Grand Total:	**$8,457,841.01**		**$229,527.38**	**$8,687,368.39**

Payment Posting, by Payor
Start Deposit Date: 1/1/2015 – End Deposit Date: 3/31/2015

Payor	Amount	%
Auto Insurance	$410,163.84	4.72%
Contract	$14,201.15	0.16%
Medicaid	$1,989,458.29	22.90%
Medicare	$3,632,222.28	41.81%
NA	$26,664.04	0.31%
Private Insurance	$1,659,998.64	19.11%
Self Pay	$865,124.38	9.96%
Workers Comp	$89,535.77	1.03%
Grand Total:	**$8,687,368.39**	**100.00%**

Report also includes
- Payment Posting, by Date of Service
- Batch Detail
- Transaction Detail

Insurance Aged Receivables

Insurance Aged Receivables

Start Date: 1/1/2015 – End Date: 3/31/2015

Primary Insurance Name	Insurance Type	# of Accounts	Current Charges	Adjustments	WriteOffs	Payments	Balance
21st Century	Private Insurance	1	$960	$0	$0	$960	$0
21st Century Auto	Auto Insurance	4	$3,190	$1,643	$0	$1,497	$50
21st Century Auto Insurance	Auto Insurance	1	$960	$0	$0	$0	$960
AAA	Auto Insurance	1	$970	$522	$0	$448	$0
AAA Mid-Atlantic Ins Group	Auto Insurance	3	$3,070	$1,633	$0	$1,437	$0
AARP	Private Insurance	1	$970	$571	$0	$399	$0
Access General	Auto Insurance	7	$7,290	$2,811	$0	$1,777	$2,702
Access Health Solution	Medicaid	1	$960	$960	$0	$0	$0
Access Insurance	Auto Insurance	2	$2,200	$702	$0	$388	$1,110
Access Insurance Company	Auto Insurance	1	$1,010	$812	$0	$198	$0
ACE North American Claims	Work Comp	1	$1,150	$0	$0	$0	$1,150
ADAC-Schutzbrief	Private Insurance	1	$960	$0	$0	$0	$960
Advantra Freedom	Medicare	118	$122,710	$66,007	$0	$30,418	$26,285
Aetna	Medicare	58	$59,340	$33,904	$0	$26,204	$-768
Aetna	Private Insurance	733	$757,020	$44,697	$1,594	$413,733	$296,995
Aetna Better Health	Medicaid	1	$990	$990	$0	$0	$0
Aetna Better Health - PA	Medicaid	1,168	$1,180,910	$987,579	$562	$110,418	$82,351
Aetna Mcare HMO	Medicare	454	$475,030	$259,606	$3,410	$132,994	$79,020
Aetna PPO Mcare	Medicare	1	$1,020	$632	$0	$388	$0
Aflac	Private Insurance	1	$980	$0	$0	$0	$980
AIC	Auto Insurance	1	$970	$532	$0	$438	$0
AIG Travel	Private Insurance	1	$970	$0	$0	$0	$970
Albert Einstein Medical Center	Private Insurance	1	$1,150	$0	$0	$0	$1,150
All American Hospice LLC	Medicare	1	$950	$0	$0	$0	$950
Allied Property and Casualty	Auto Insurance	1	$960	$0	$0	$0	$960
Allstate	Auto Insurance	1	$1,010	$572	$0	$438	$0
AllState	Auto Insurance	2	$2,080	$1,203	$0	$927	$-50
Allstate Auto Insurance	Auto Insurance	8	$8,000	$3,308	$0	$4,202	$490
Allstate Ins	Auto Insurance	2	$1,960	$1,068	$0	$892	$0

Report also includes

- Insurance Aged Receivables Detail by Account
- Accounts reported to collection agency (if appropriate)

Call Statistics

Response Times

Start Date: 1/1/2015 – End Date: 3/31/2015

Unit Status	Jan	Feb	Mar	Totals:
Dispatch - Location	541.77s	544.59s	539.33s	**541.9s**
	9.03m	9.08m	8.99m	**9.03m**
Location - To Hospital	823.31s	836.52s	851.64s	**837.16s**
	13.72m	13.94m	14.19m	**13.95m**
To Hospital - At Hospital	609.42s	623.42s	616.4s	**616.42s**
	10.16m	10.39m	10.27m	**10.27m**
At Hospital - In Service	1,298.67s	1,271.41s	1,296.01s	**1,288.7s**
	21.64m	21.19m	21.6m	**21.48m**
Location - At Hospital	1,365.34s	1,389.75s	1,398.94s	**1,384.68s**
	22.76m	23.16m	23.32m	**23.08m**
Dispatch - At Hospital	1,903.6s	1,945.25s	1,943.68s	**1,930.85s**
	31.73m	32.42m	32.39m	**32.18m**
Dispatch - In Service	2,826.34s	2,831.05s	2,851.09s	**2,836.16s**
	47.11m	47.18m	47.52m	**47.27m**

Patient Disposition

Start Date: 1/1/2015 – End Date: 3/31/2015

Disposition	Jan	Feb	Mar	Totals:
Total Encounters	**20850**	**18346**	**20483**	**59679**
Transport and treatment	16332	14338	15983	**46653**
	78.33%	78.15%	78.03%	**78.17%**
Treatment, no transport	186	143	166	**495**
	0.89%	0.78%	0.81%	**0.83%**
No treatment, no transport	662	572	640	**1874**
	3.18%	3.12%	3.12%	**3.14%**
Call cancelled	1848	1650	1823	**5321**
	8.86%	8.99%	8.90%	**8.92%**
Dead on scene	275	242	260	**777**
	1.32%	1.32%	1.27%	**1.30%**
False Alarm/ Unfounded/ No Pt	1547	1401	1611	**4559**
	7.42%	7.64%	7.87%	**7.64%**

Transports by Facility

Start Date: 1/1/2015 – End Date: 3/31/2015

Facility Name	Jan	Feb	Mar	Totals:
AA Hospital	3	8	3	**14**
	0.01%	0.04%	0.01%	**0.02%**
BB Medical Center	1954	1757	2101	**5812**
	9.37%	9.58%	10.26%	**9.74%**
CC Health	1040	932	1099	**3071**
	4.99%	5.08%	5.37%	**5.15%**
DD Health	760	653	735	**2148**
	3.65%	3.56%	3.59%	**3.60%**
EE Hospital	323	234	260	**817**
	1.55%	1.28%	1.27%	**1.37%**
FF Children's Hospital	543	463	492	**1498**
	2.60%	2.52%	2.40%	**2.51%**

Calls by Time of Day

Start Date: 1/1/2015 – End Date: 3/31/2015

Time	Jan	Feb	Mar	Totals
0000-0559	3321	2876	3177	**9374**
	15.93%	15.68%	15.51%	**15.71%**
0600-1159	5440	4809	5208	**15457**
	26.09%	26.21%	25.43%	**25.90%**
1200-1759	6622	5754	6581	**18957**
	31.76%	31.36%	32.13%	**31.76%**
1800-2359	5467	4907	5517	**15891**
	26.22%	26.75%	26.93%	**26.63%**

Report also includes

- Patient Age
- Dispatched Call Types
- Call Locations
- Unit Transports

ePCR Demographic Capture

ePCR Demographic Capture by Medic

Start Date: 1/1/2015 – End Date: 3/31/2015

PrimaryMedic Full Name	No. of Accounts	ePCR % with SSN	ePCR % with DoB	ePCR % with Home Phone	ePCR % with ZIP Code	ePCR % with Address
AAAA, AAAA	4	100.%	100.%	100.%	100.%	100.%
BBBB, BBBB	14	79.%	100.%	50.%	100.%	100.%
CCCC, CCCC	10	80.%	100.%	60.%	100.%	100.%
DDDD, DDDD	49	73.%	100.%	10.%	100.%	100.%
EEEE, EEEE	4	25.%	100.%	0.%	100.%	100.%
FFFF, FFFF	27	70.%	100.%	44.%	100.%	100.%
GGGG, GGGG	11	73.%	100.%	36.%	100.%	100.%
HHHH, HHHH	140	71.%	100.%	44.%	99.%	100.%
IIII, IIII	12	67.%	100.%	17.%	100.%	100.%
JJJJ, JJJJ	5	60.%	100.%	60.%	100.%	100.%
KKKK, KKKK	38	39.%	100.%	26.%	100.%	100.%
LLLL, LLLL	52	85.%	100.%	46.%	100.%	100.%
MMMM, MMMM	22	82.%	100.%	50.%	100.%	100.%
NNNN, NNNN	16	75.%	100.%	81.%	100.%	100.%
OOOO, OOOO	75	77.%	100.%	40.%	100.%	100.%
PPPP, PPPP	30	83.%	100.%	57.%	100.%	100.%

ePCR Demographic Capture by Month of Service

Start Date: 1/1/2015 – End Date: 3/31/2015

Month of Service	Number of Accounts	ePCR % with SSN	ePCR % with DoB	ePCR % with Home Phone	ePCR % with ZIP Code	ePCR % with Address
2015-01	16029	75.%	100.%	51.%	100.%	100.%
2015-02	14058	76.%	100.%	52.%	100.%	100.%
2015-03	15642	77.%	100.%	51.%	100.%	100.%

Invalid Signatures and 'NMN' Summary

Medicare Summary – Invalid Signatures and 'Not Medically Necessary'

Start Date: 1/1/2015 – End Date: 3/31/2015

		Total Medicare (Count/%)		Medicare Invalid Signature Accounts			Medicare Not Medically Necessary		
Month of Service	Total Billable Incidents	Medicare Billable Incidents	% of Total AR	Count of Invalid Signatures	% Invalid of Medicare	% Invalid of Total AR	Count of NMN	% NMN of Medicare	% NMN of Total AR
2015-01	16,453	5,260	31.97%	163	3.10%	0.99%	263	5.00%	1.60%
2015-02	14,399	4,580	31.81%	128	2.79%	0.89%	198	4.32%	1.38%
2015-03	16,051	5,012	31.23%	147	2.93%	0.92%	200	3.99%	1.25%
Totals:	**46,903**	**14,852**	**31.67%**	**438**	**2.95%**	**0.93%**	**661**	**4.45%**	**1.41%**

Medicaid Summary – Invalid Signatures and 'Not Medically Necessary'

Start Date: 1/1/2015 – End Date: 3/31/2015

		Total Medicaid (Count/%)		Medicaid Not Medically Necessary		
Month of Service	Total Billable Incidents	Medicaid Billable Incidents	% of Total AR	Count of NMN	% NMN of Medicaid	% NMN of Total AR
2015-01	16,453	6,775	41.18%			
2015-02	14,399	6,036	41.92%			
2015-03	16,051	6,978	43.47%			
Totals:	**46,903**	**19789**	**42.19%**			

Commercial Summary – Invalid Signatures and 'Not Medically Necessary'

Start Date: 1/1/2015 – End Date: 3/31/2015

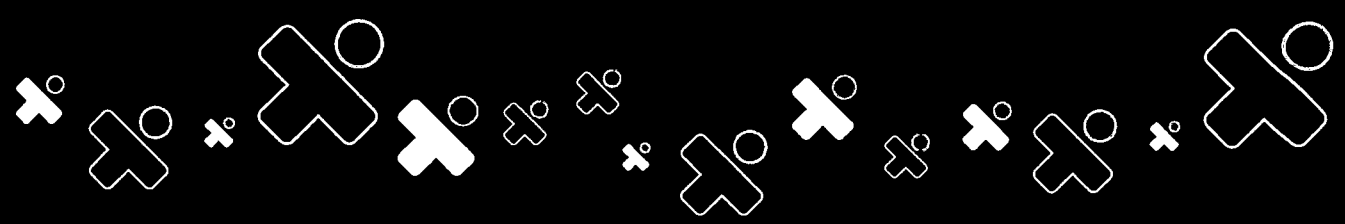
		Total Commercial (Count/%		Commercial Invalid Signature Accounts		
Month of Service	Total Billable Incidents	Commercial Billable Incidents	% of Total AR	Count of Invalid Signatures	% Invalid of Commercial	% Invalid of Total AR
2015-01	16,453	1,919	11.66%	3	0.16%	0.02%
2015-02	14,399	1,701	11.81%	0	0.00%	0.00%
2015-03	16,051	1,845	11.49%	1	0.05%	0.01%
Totals:	**46,903**	**5465**	**11.65%**	**4**	**0.07%**	**0.01%**

Report also includes

- Medicare Invalid Signature Detail
- Medicare NMN Detail
- Medicaid NMN Detail
- Commercial Invalid Signature Detail

RFP #2017-1-37

VIII. Billing Processes



VIII. BILLING PROCESSES

Provide information for the following:

- **Describe process to bill, collect and audit in compliance with all federal, state and local regulations; including internal controls and "checks and balances" process that has been implemented to ensure proper billing compliance on an ongoing basis with all applicable regulations.**

  We assess every patient record before it becomes a claim for completeness and accuracy of the information received in the PCR along with any supplemental documents that might be provided. Our coders are looking at the entirety of the documentation to make their coding determinations. We pay special attention to gathering medical necessity, patient certification statements, justification for level of service and other documentation required by payers. Whenever paper copies are required, we print and submit those claims manually. Our billing system automatically fills in all pertinent data to the appropriate fields of the CMS HCFA 1500 form and batches the claim for daily printing when electronic claim routing is not an option.

  We also apply processes such as skip tracing when relevant to help us locate an individual if we do not have insurance information available.

- **Process for gathering missing transport information (client or insurance)**

  We place intense operational efforts on our front-end processes with the primary goal of obtaining patient demographic and insurance information wherever it exists. Our billing methodology includes a combination of technology, people and processes designed to locate patient information from receiving facilities, insurance databases, transport records, skip-tracing resources and patient phone calls. Our system will also search all historical transports for patient information in case demographics and insurance information exist from a previous transport.

  The following provides an overview of the technology and processes used and how our people successfully execute our methodology:

  Returned mail – All returned mail is researched and sent through the same processes and sweeps performed on the initial transport to identify any additional information that may have become available.

  Eligibility – We execute a series of insurance eligibility transactions to help retrieve appropriate insurance information. To ensure the information is complete, we interface with external sources such as Medicare HIPAA Eligibility Transaction System (HETS), and various commercial partners. Our Hospital Liaison Program supplements this data by focusing on connecting with your receiving facilities to gather demographic and insurance information from their onsite registration staff to augment the data in our database.

Database and Hospital Collection – We have developed a master database application within our proprietary billing system for internal eligibility and demographic sweeps. We run the application along with the data from all your transport facilities against our nationwide database. This ensures that claims will access local patient data in a real-time environment every time a run is submitted. In turn, this increases the opportunity to obtain the necessary data to accurately bill a claim the first time.

User Research – If demographic or insurance information is missing or incomplete, each account is manually researched using external databases, skip-tracing and outbound phone calls.

All of these steps enable us to better identify the correct information to pursue payments on your behalf when initially received with unbillable information.

- **Process for billing mileage**

  Our compliant coding process includes medical necessity determination, signature verification, confirmation of submitted mileage calculation, and level of service determination facilitated by professional coders. Once in the system, mileage that is billed and paid is easy to track and report upon per station and by deposit date. This type of reporting can be set up to run on a scheduled basis or be run on-demand by the City.

- **Process for reporting on billing and collections**

  Intermedix offers a library of reports that have been developed specifically for EMS agencies to gain meaningful insight into the effectiveness of their billing operations. Our standard library of EMS reports includes an array of financial data reports as well as medic statistics and key performance indicators.

  Reports can be scheduled to run on a regular basis (monthly), or run on-demand by authorized client users via an internet-enabled computer.

- **Process for re-filing of rejected claims**

  Our goal is to file a clean claim the first time; however, denials do occur. In case of a denial, we initiate a series of actions specific to the denial reason.

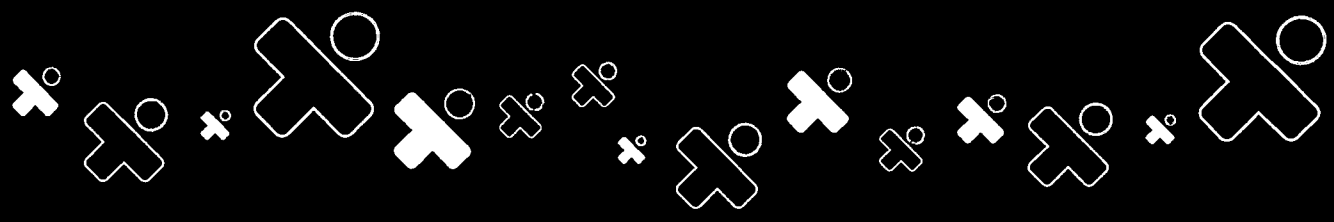
  We are committed to timely and accurate processing to improve cash flow, and address many denials automatically upon receipt. We are continuously expanding the payer and denial code combinations that can be handled automatically. Denials that are not processed automatically are addressed by Accounts Receivable resources through our Manual Denial Management Queue.

  We engage in a number of activities to resolve accounts such as researching accounts, verifying electronic claim status, accessing payer websites and making payer phone calls. Once the problem has been identified, we update accounts and re-file claims

when appropriate. The queue allows sorting by payer, so that our representatives can quickly resolve multiple claim issues for a single payer at the same time.

RFP #2017-1-37

IX. Collection & Customer Service Processes



IX. COLLECTION & CUSTOMER SERVICE PROCESSES

Provide a detailed collection solution which addresses the following:

- **Process for identification and collection of delinquent accounts which reflect the City's collection philosophy (stated on page 14, Allen Fire Department Background)**

  We have developed monitoring tools that allow us to follow-up on claims that have not been paid in the expected timeframe. Our staff is assigned to these work queues to avoid cases where claims are submitted without a payer response. Accurate data mining of denials is the most critical element of our denial management process.

  This "Claims Status Monitor" queue monitors activity on accounts with primary and secondary insurance, an open status, and a balance that is not equal to zero. It recognizes the insurance process date and searches for a response from the payer.

  Intermedix is not a collection agency. When 120 days has passed since transport with no contact from the patient, we will turn the account over to a collection agency of the City's choosing.

- **Company's collection process. Please provide dialogs, scripts, forms or letters. Please highlight any aspects of your company's collections capabilities that distinguish it from other firms offering the same or similar services.**

  Intermedix is not a collection agency. When 120 days has passed since transport with no contact from the patient, we will turn the account over to a collection agency of the City's choosing.

- **Process for reporting uncollected/delinquent accounts**

  After exhausting all efforts–including applying payments, adjustments and write-offs–accounts with open balances may become eligible for advanced collections. After a final review to ensure no recent account activity, we will send the patient an invoice warning them that the account will potentially be sent to collections if left unpaid. Then, upon written direction by the City, we will release the account to collections by electronically providing the designated vendor with the necessary data to perform collection services.

- **Process to provide multiple payment methods to customers and a description of all available options**

  Our proprietary billing system supports a wide variety of electronic payment methods, including electronic fund transfers (EFTs), checks and credit cards for patients. Most payers, including Medicare and Medicaid, receive and remit electronically directly into our billing system. This functionality is a standard part of our proposal and will not incur any costs to the client.

- **Process for handling customer inquiries through multiple media (email, telephone, written), including response times, performance measurements and goals.**

  We have a dedicated patient contact center that is staffed with experience patient account representatives who are available by toll free number from 8:00 a.m. to 8:00 p.m. every weekday. Patients can also leave a voicemail that will be returned within 1 business day. All patient inquiries will be handled according to the guidelines provided by the City, with you providing the final determination on any escalated issues.

- **Process which allows the customer to view their account**

  Intermedix offers a self-service patient portal to all of our clients, allowing patients to log in at their convenience and update contact, insurance, or payment details. If the client enters into a merchant agreement with our online payment partner, the option to make payments becomes available to the patients. They will be presented with a "Make Payment" button through which they will be redirected seamlessly to the online payment site to update insurance and/or pay by credit card or electronic check.

- **Process for maintaining and keeping active all certifications required such as Medicare and Medicaid on behalf of the City of Allen.**

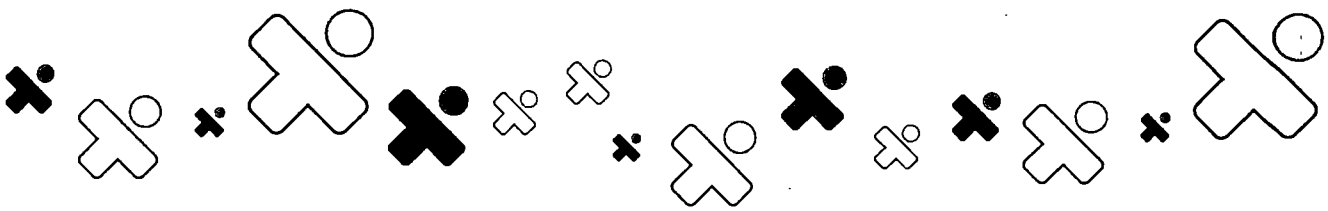
  We will take care of maintaining and keeping active all certifications required such as Medicare and Medicaid on behalf of the City. Intermedix keeps up-to-date on the changing regulations in the industry. By continuing your relationship with us, we ensure that you will keep up with industry trends.

- **Explain for customer service process for City of Allen staff. Provide contact information, hours of operation, expected turnaround time for problem resolution.**

  Our goal is to resolve patient inquiries within the first call; however, when that isn't possible, our patient account representatives seek to provide resolution back to the patient within two business days to allow time for research or follow up that needs to occur to answer the question or handle the issue. Patients can also leave a voicemail message that will be returned within one (1) business day.

RFP #2017-1-37

SAS 70 Type II Certification



intermedix

January 4, 2017

Re: Comments on Period Subsequent to the 2016 SOC 1 Examination Period

Dear Intermedix Client:

As you may know, Intermedix Corporation completed a Type 2 SOC 1 examination in August 2016. The review period for that examination was July 1, 2015 to June 30, 2016. The scope of the report included Revenue Cycle Management services.

The objective of this letter is to provide our clients and our clients' external financial statement auditors with an update regarding our services and the related controls included in the scope of the SOC 1 report for the period of time that has elapsed since the end of the review period. In light of this, please be advised that the following statements are true to the best of our knowledge for the period of time between the conclusion of the review period and the date of this letter:

- There have been no events subsequent to the review period of the report that would have a significant effect on our assertions contained within the report.
- There have been no significant changes to our services or the underlying processes and/or systems since the conclusion of the review period.
- There have been no significant changes to our control objectives or the related control activities described in the SOC 1 report since the conclusion of the review period.
- The control activities that govern our services have operated as described in the SOC 1 report since the conclusion of the review period.
- We are not aware of any significant operating or design deficiencies specific to the control activities described in the SOC 1 report that have occurred since the conclusion of the review period.

If you have any further questions regarding this topic, please contact your Client Services Representative.

Sincerely,

Joel Portice
CEO

SECTION VII
PRICING

Vendors should submit one original pricing sheet.

This pricing sheet should be submitted in a sealed envelope separate from the proposal documents. Please print Company Name, 2017-1-37 Pricing Sheet on the outside of your envelope. You must submit this sheet at the time you submit your proposal, your proposal will be non-responsive without this information.

Do not include this information in the requested proposal copies.

DESCRIPTION	COMMISSION RATE BASED ON COLLECTIONS Percentage of collections to be Paid to Vendor
Commission Rate – Billing for EMS Services	5.95 % *This price includes RCM and TripTix.

COMPANY NAME: Advanced Data Processing, Inc., a subsidiary of Intermedix Corporation

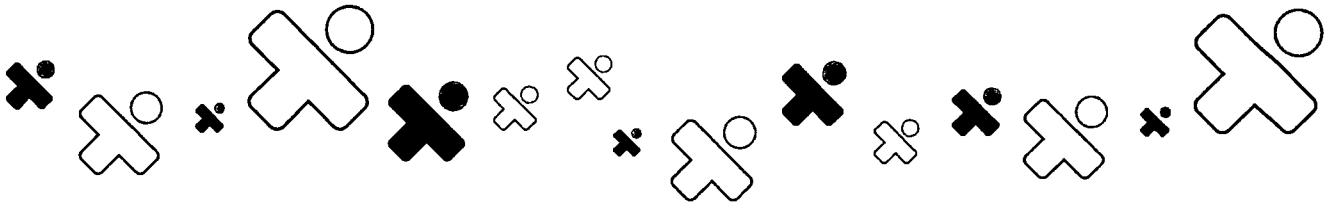
SIGNATURE: _____ **DATE:** 2/21/2017

PRINTED NAME: Michael Wallace **TITLE:** Chief Financial Officer

EXHIBIT "C"
INSURANCE REQUIREMENTS

RFP #2017-1-37

Certificate of Insurance



ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
06/17/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA Inc. 1560 Sawgrass Corporate Pkwy, Suite 300 Sunrise, FL 33323 Attn: FtLauderdale.CertRequest@marsh.com F:212-948-0512 101309-GAWU-PROF-16-17	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED Intermedix Corporation 6451 North Federal Highway, Suite 1000 Fort Lauderdale, FL 33308	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Continental Insurance Company — 35289 INSURER B : American Casualty Company Of Reading, Pa — 20427 INSURER C : N/A — N/A INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: ATL-003492461-19 REVISION NUMBER:6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X COMMERCIAL GENERAL LIABILITY			6018302277	06/30/2016	06/30/2017	EACH OCCURRENCE	$	1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	1,000,000
							MED EXP (Any one person)	$	15,000
							PERSONAL & ADV INJURY	$	1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$	2,000,000
	POLICY [ ] PRO-JECT [X] LOC						PRODUCTS - COMP/OP AGG	$	2,000,000
	OTHER:							$	
A	AUTOMOBILE LIABILITY			6018302263	06/30/2016	06/30/2017	COMBINED SINGLE LIMIT (Ea accident)	$	1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$	
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$	
								$	
A	X UMBRELLA LIAB X OCCUR			6018302232	06/30/2016	06/30/2017	EACH OCCURRENCE	$	5,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$	5,000,000
	DED X RETENTION $ 10,000							$	
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			6018302294 (AOS)	06/30/2016	06/30/2017	X PER STATUTE [ ] OTH-ER		
B	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] N/A			6018302280 (CA)	06/30/2016	06/30/2017	E.L. EACH ACCIDENT	$	1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$	1,000,000
							E.L. DISEASE - POLICY LIMIT	$	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Wise County, its Officers, Officials, Employees and Volunteers are included as additional insured where required by written contract with respect to general liability and automobile liability. Waiver of subrogation is applicable where required by written contract with respect to general liability and automobile liability.

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Carmen Gordon

EXHIBIT "D"
BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into between City of Allen, TX ("Covered Entity") and Advanced Data Processing, Inc., a subsidiary of Intermedix Corporation, a Delaware Corporation ("Business Associate"), effective as of the date executed by both parties below (the "Effective Date").

WHEREAS, Covered Entity and Business Associate have entered into, or plan to enter into, an agreement or other documented arrangement (the "Underlying Agreement"), pursuant to which Business Associate may provide services for Covered Entity that require Business Associate to access, create and use Protected Health Information ("PHI") that is confidential under state and/or federal law; and

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed by Covered Entity to Business Associate, or collected or created by Business Associate pursuant to the Underlying Agreement, in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and the regulations promulgated there under, including, without limitation, the regulations codified at 45 CFR Parts 160 and 164 ("HIPAA Regulations"); the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations and guidance issued by the Secretary of the Department of Health and Human Services (the "Secretary") (the "HITECH Act"); and other applicable state and federal laws, all as amended from time to time, including as amended by the Final Rule issued by the Secretary on January 17, 2013 titled "Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules"; and

WHEREAS, the HIPAA Regulations require Covered Entity to enter into an agreement with Business Associate meeting certain requirements with respect to the Use and Disclosure of PHI, which are met by this Agreement.

NOW, THEREFORE, in consideration of the mutual promises contained herein and the exchange of information pursuant to this Agreement, the parties agree as follows:

1. Definitions.

Capitalized terms used herein without definition shall have the meanings ascribed to them in the HIPAA Regulations or the HITECH Act, as applicable unless otherwise defined herein.

2. Obligations of Business Associate.

a. Permitted Uses and Disclosures. Business Associate shall only Use or Disclose PHI for the purposes of (i) performing Business Associate's obligations under the Underlying Agreement and as permitted by this Agreement; or (ii) as permitted or Required By Law; or (iii) as otherwise permitted by this Agreement. Business Associate shall not Use or further Disclose PHI other than as permitted or required by this Agreement or as Required By Law. Further, Business Associate shall not Use or Disclose PHI in any manner that would constitute a violation of the HIPAA Regulations or the HITECH Act if so used by Covered Entity, except that Business Associate may Use PHI (i) for the proper management and administration of Business Associate; and (ii) to carry out the legal responsibilities of Business Associate. Business Associate may Disclose PHI for the proper management and administration of Business Associate, to carry out its legal responsibilities or for payment purposes as specified in 45 CFR § 164.506(c)(1) and (3), including but not limited to Disclosure to a business associate on behalf of a

covered entity or health care provider for payment purposes of such covered entity or health care provider, with the expectation that such parties will provide reciprocal assistance to Covered Entity, provided that with respect to any such Disclosure either: (i) the Disclosure is Required By Law; or (ii) for permitted Disclosures when Required By Law, Business Associate shall obtain a written agreement from the person to whom the PHI is to be Disclosed that such person will hold the PHI in confidence and will not use and further disclose such PHI except as Required By Law and for the purpose(s) for which it was Disclosed by Business Associate to such person, and that such person will notify Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

b. Creation and Use of De-Identified Data. Business Associate may de-identify any and all PHI, provided that any process or mechanism used to de-identify the data meets the requirements of 45 C.F.R 164.514(a)-(b). Business Associate may use or disclose (and permit others to use or disclose) such de-identified data on a perpetual unrestricted basis, but in no case shall Business Associate attempt to run or develop any keys, codes or algorithms that may be used to re-identify the data.

c. Appropriate Safeguards. Business Associate shall implement administrative, physical and technical safeguards that (i) reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity; and (ii) prevent the Use or Disclosure of PHI other than as contemplated by the Underlying Agreement and this Agreement.

d. Compliance with Security Provisions. Business Associate shall: (i) implement and maintain administrative safeguards as required by 45 CFR § 164.308, physical safeguards as required by 45 CFR § 164.310 and technical safeguards as required by 45 CFR § 164.312; (ii) implement and document reasonable and appropriate policies and procedures as required by 45 CFR § 164.316; and (iii) be in compliance with all requirements of the HITECH Act related to security and applicable as if Business Associate were a "covered entity," as such term is defined in HIPAA.

e. Compliance with Privacy Provisions. Business Associate shall only Use and Disclose PHI in compliance with each applicable requirement of 45 CFR § 164.504(e). Business Associate shall comply with all requirements of the HITECH Act related to privacy and applicable as if Business Associate were a "covered entity," as such term is defined in HIPAA. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

f. Duty to Mitigate. Business Associate agrees to mitigate, to the extent practicable and mandated by law, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

g. Encryption. To facilitate Business Associate's compliance with this Agreement and to assure adequate data security, Covered Entity agrees that all PHI provided or transmitted to Business Associate pursuant to the Underlying Agreement shall be provided or transmitted in a manner which renders such PHI unusable, unreadable or indecipherable to unauthorized persons, through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of the HITECH Act. Covered Entity acknowledges that failure to do so could contribute to or permit a Breach requiring patient notification under the HITECH Act and further agrees that Business Associate shall have no liability for any Breach caused by such failure.

3. Reporting.

a. Security Incidents and/or Unauthorized Use or Disclosure. Business Associate shall report to Covered Entity a successful Security Incident or any Use and/or Disclosure of PHI other than as provided for by this Agreement or permitted by applicable law within a reasonable time of becoming aware of such Security Incident and/or unauthorized Use or Disclosure (but not later than ten (10) days thereafter), in accordance with the notice provisions set forth herein. Business Associate shall take (i) prompt action to cure any such deficiencies as reasonably requested by Covered Entity, and (ii) any action pertaining to such Security Incident and/or unauthorized Use or Disclosure required by applicable federal and state laws and regulations. If such successful Security Incident or unauthorized Use or Disclosure results in a Breach as defined in the HITECH Act, then Covered Entity shall comply with the requirements of Section 3.b below. The Parties acknowledge and agree that this Section constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents as defined herein. "Unsuccessful Security Incidents" will include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

b. Breach of Unsecured PHI. The provisions of this Section 3.b are effective with respect to the Discovery of a Breach of Unsecured PHI occurring on or after September 23, 2009. With respect to any unauthorized acquisition, access, Use or Disclosure of Covered Entity's PHI by Business Associate, its agents or subcontractors, Business Associate shall (i) investigate such unauthorized acquisition, access, Use or Disclosure; (ii) determine whether such unauthorized acquisition, access, Use or Disclosure constitutes a reportable Breach under the HITECH Act; and (iii) document and retain its findings under clauses (i) and (ii). If Business Associate Discovers that a reportable Breach has occurred, Business Associate shall notify Covered Entity of such reportable Breach in writing within thirty (30) days of the date Business Associate Discovers such Breach. Business Associate shall be deemed to have discovered a Breach as of the first day that the Breach is either known to Business Associate or any of its employees, officers or agents, other than the person who committed the Breach, or by exercising reasonable diligence should have been known to Business Associate or any of its employees, officers or agents, other than the person who committed the Breach. To the extent the information is available to Business Associate, Business Associate's written notice shall include the information required by 45 CFR § 164.410(c). Business Associate shall promptly supplement the written report with additional information regarding the Breach as it obtains such information. Business Associate shall cooperate with Covered Entity in meeting Covered Entity's obligations under the HITECH Act with respect to such Breach.

4. Business Associate's Agents. To the extent that Business Associate uses one or more subcontractors or agents to provide services under the Underlying Agreement, and such subcontractors or agents receive or have access to PHI, Business Associate shall sign an agreement with such subcontractors or agents containing substantially the same provisions as this Agreement.

5. Rights of Individuals.

a. Access to PHI. Within ten (10) days of receipt of a request by Covered Entity, Business Associate shall make PHI maintained in a Designated Record Set available to Covered Entity or, as directed by Covered Entity, to an Individual to enable Covered Entity to fulfill its obligations under 45 CFR § 164.524. Subject to Section 5.b below, (i) in the event that any Individual requests access to PHI directly from Business Associate in connection with a routine billing inquiry, Business Associate shall directly respond to such request in compliance with 45 CFR § 164.524; and (ii) in the event such request appears to be for a purpose other than a routine billing inquiry, Business Associate shall forward a copy of such request to Covered Entity and shall fully cooperate with Covered Entity in responding to such

request. In either case, a denial of access to requested PHI shall not be made without the prior written consent of Covered Entity.

b. Access to Electronic Health Records. If Business Associate is deemed to use or maintain an Electronic Health Record on behalf of Covered Entity with respect to PHI, then, to the extent an Individual has the right to request a copy of the PHI maintained in such Electronic Health Record pursuant to 45 CFR § 164.524 and makes such a request to Business Associate, Business Associate shall provide such Individual with a copy of the information contained in such Electronic Health Record in an electronic format and, if the Individual so chooses, transmit such copy directly to an entity or person designated by the Individual. Business Associate may charge a fee to the Individual for providing a copy of such information, but such fee may not exceed Business Associate's labor costs in responding to the request for the copy. The provisions of 45 CFR § 164.524, including the exceptions to the requirement to provide a copy of PHI, shall otherwise apply and Business Associate shall comply therewith as if Business Associate were the "covered entity," as such term is defined in HIPAA. At Covered Entity's request, Business Associate shall provide Covered Entity with a copy of an Individual's PHI maintained in an Electronic Health Record in an electronic format and in a time and manner designated by Covered Entity in order for Covered Entity to comply with 45 CFR § 164.524, as amended by the HITECH Act.

c. Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

d. Accounting Rights. This Section 5.d is subject to Section 5.e below. Business Associate shall make available to Covered Entity, in response to a request from an Individual, information required for an accounting of disclosures of PHI with respect to the Individual, in accordance with 45 CFR § 164.528, incorporating exceptions to such accounting designated under such regulation. Such accounting is limited to disclosures that were made in the six (6) years prior to the request and shall not include any disclosures that were made prior to the compliance date of the HIPAA Regulations. Business Associate shall provide such information as is necessary to provide an accounting within ten (10) days of Covered Entity's request. Such accounting must be provided without cost to the Individual or to Covered Entity if it is the first accounting requested by an Individual within any twelve (12) month period; however, a reasonable, cost-based fee may be charged for subsequent accountings if Business Associate informs Covered Entity and Covered Entity informs the Individual in advance of the fee, and the Individual is afforded an opportunity to withdraw or modify the request. Such accounting obligations shall survive termination of this Agreement and shall continue as long as Business Associate maintains PHI.

e. Accounting of Disclosures of Electronic Health Records. The provisions of this Section 5.e shall be effective on the date specified in the HITECH Act. If Business Associate is deemed to use or maintain an Electronic Health Record on behalf of Covered Entity, then, in addition to complying with the requirements set forth in Section 5.d above, Business Associate shall maintain an accounting of any Disclosures made through such Electronic Health Record for Treatment, Payment and Health Care Operations, as applicable. Such accounting shall comply with the requirements of the HITECH Act. Upon request by Covered Entity, Business Associate shall provide such accounting to Covered Entity in the time and manner specified by Covered Entity and in compliance with the HITECH Act. Alternatively, if Covered Entity responds to an Individual's request for an accounting of Disclosures made through an Electronic Health Record by providing the requesting Individual with a list of all business associates acting on behalf of Covered Entity, then Business Associate shall provide such accounting directly to the requesting Individual in the time and manner specified by the HITECH Act.

f. Agreement to Restrict Disclosure. If Covered Entity is required to comply with a restriction on the Disclosure of PHI pursuant to Section 13405 of the HITECH Act, then Covered Entity shall, to the extent necessary to comply with such restriction, provide written notice to Business Associate of the name of the Individual requesting the restriction and the PHI affected thereby. Business Associate shall, upon receipt of such notification, not Disclose the identified PHI to any health plan for the purposes of carrying out Payment or Health Care Operations, except as otherwise required by law. Covered Entity shall also notify Business Associate of any other restriction to the Use or Disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522.

6. Remuneration and Marketing.

a. Remuneration for PHI. This Section 6.a shall be effective with respect to exchanges of PHI occurring six (6) months after the date of the promulgation of final regulations implementing the provisions of Section 13405(d) of the HITECH Act. On and after such date, Business Associate agrees that it shall not, directly or indirectly, receive remuneration in exchange for any PHI of Covered Entity except as otherwise permitted by the HITECH Act.

b. Limitations on Use of PHI for Marketing Purposes. Business Associate shall not Use or Disclose PHI for the purpose of making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, unless such communication: (1) complies with the requirements of subparagraph (i), (ii) or (iii) of paragraph (1) of the definition of marketing contained in 45 CFR § 164.501, and (2) complies with the requirements of subparagraphs (A), (B) or (C) of Section 13406(a)(2) of the HITECH Act, and implementing regulations or guidance that may be issued or amended from time to time. Covered Entity agrees to assist Business Associate in determining if the foregoing requirements are met with respect to any such marketing communication.

7. Governmental Access to Records. Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Regulations and the HITECH Act. Except to the extent prohibited by law, Business Associate agrees to notify Covered Entity of all requests served upon Business Associate for information or documentation by or on behalf of the Secretary. Business Associate shall provide to Covered Entity a copy of any PHI that Business Associate provides to the Secretary concurrently with providing such PHI to the Secretary.

8. Minimum Necessary. To the extent required by the HITECH Act, Business Associate shall limit its Use, Disclosure or request of PHI to the Limited Data Set or, if needed, to the minimum necessary to accomplish the intended Use, Disclosure or request, respectively. Effective on the date the Secretary issues guidance on what constitutes "minimum necessary" for purposes of the HIPAA Regulations, Business Associate shall limit its Use, Disclosure or request of PHI to only the minimum necessary as set forth in such guidance.

9. State Privacy Laws. Business Associate shall comply with state laws to extent that such state privacy laws are not preempted by HIPAA or the HITECH Act.

10. Termination.

a. Breach by Business Associate. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Agreement, then Covered Entity shall promptly notify Business Associate. With respect to such breach or violation, Business Associate shall take reasonable steps to cure such breach or

end such violation, if possible. If such steps are either not possible or are unsuccessful, upon written notice to Business Associate, Covered Entity may terminate its relationship with Business Associate.

b. Breach by Covered Entity. If Business Associate knows of a pattern of activity or practice of Covered Entity that constitutes a material breach or violation of Covered Entity's obligations under this Agreement, then Business Associate shall promptly notify Covered Entity. With respect to such breach or violation, Covered Entity shall take reasonable steps to cure such breach or end such violation, if possible. If such steps are either not possible or are unsuccessful, upon written notice to Covered Entity, Business Entity may terminate its relationship with Covered Entity.

c. Effect of Termination. Upon termination of this Agreement for any reason, Business Associate shall either return or destroy all PHI, as requested by Covered Entity, that Business Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI. If Covered Entity requests that Business Associate return PHI, such PHI shall be returned in a mutually agreed upon format and timeframe. If Business Associate reasonably determines that return or destruction is not feasible, Business Associate shall continue to extend the protections of this Agreement to such PHI, and limit further uses and disclosures of such PHI to those purposes that make the return or destruction of such PHI not feasible. If Business Associate is asked to destroy the PHI, Business Associate shall destroy PHI in a manner that renders the PHI unusable, unreadable or indecipherable to unauthorized persons as specified in the HITECH Act.

11. Amendment. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement any new or modified standards or requirements of HIPAA, the HIPAA Regulations, the HITECH Act and other applicable laws relating to the security or confidentiality of PHI. Upon the request of Covered Entity, Business Associate agrees to promptly enter into negotiation concerning the terms of an amendment to this Agreement incorporating any such changes.

12. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

13. Effect on Underlying Agreement. In the event of any conflict between this Agreement and the Underlying Agreement, the terms of this Agreement shall control.

14. Survival. The provisions of this Agreement shall survive the termination or expiration of the Underlying Agreement.

15. Interpretation. This Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations and the HITECH Act. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with such laws.

16. Governing Law. This Agreement shall be construed in accordance with the laws of the State of Florida.

17. Notices. All notices required or permitted under this Agreement shall be in writing and sent to the other party as directed below or as otherwise directed by either party, from time to time, by

written notice to the other. All such notices shall be deemed validly given upon receipt of such notice by certified mail, postage prepaid, facsimile transmission, e-mail or personal or courier delivery:

If to Covered Entity:

City of Allen
305 Century Parkway
Allen, TX 75070
Attn: Purchasing Division
Telephone no: 214-509-4630
Facsimile no: 214-509-4675

If to Business Associate:

Intermedix Corporation
6451 N. Federal Highway, Suite 1000
Ft. Lauderdale, FL 33308
Attn: Chief Compliance Officer
Telephone no: 954-308-8700
Facsimile no: 954-308-8725

[signature block on following page]

IN WITNESS WHEREOF, the parties hereto have duly executed this as of the Effective Date.

COVERED ENTITY	BUSINESS ASSOCIATE
By: _____	By: Brad Williams
Name: Peter H. Vargas	Name: Brad Williams
Title: City Manager	Title: VP + CAO
Date: _____	Date: 4/13/17

EXHIBIT "E"
TRIP TIX ADDENDUM

Exhibit D
(TripTix® Program)

This Exhibit D, effective as of the Effective Date of the Agreement, hereby sets forth terms and conditions that apply only to the Product and Product Units listed in this Exhibit D. In regards to the Product, to the extent the terms and conditions of the Agreement are in conflict with this Exhibit D, the terms of this Exhibit D shall control. Where not different or in conflict with the terms, conditions and definitions of this Exhibit D, all applicable terms, conditions, and definitions set forth in the Agreement are incorporated within this Exhibit D as if set forth herein. Capitalized terms used herein and not otherwise defined herein shall have the meaning given to such terms in the Agreement.

WHEREAS, Intermedix has developed the TripTix® solution or product running on personal tablet devices to enter medical records and data into and interact with its main billing and medical records system or Billing System ("Product" as more particularly defined herein) that Intermedix is willing to make available to Client to use during the Term of the Agreement, as well as subject to the terms and conditions set forth herein; and

WHEREAS, Client has expressed a desire to obtain a right to use the Product; and

WHEREAS, Client acknowledges that, in connection with the provision of the Product and the Product Unit, Intermedix is incurring significant per unit and, in some cases, per User out of pocket expenses;

NOW, THEREFORE, the parties agree as follows:

ARTICLE I. DEFINITIONS

1.01 Definitions. For purposes of this Exhibit D, the following definitions shall apply:

(a) "Addendum Effective Date" shall mean the date on which the last party to this Addendum executed it.

(b) "Intellectual Property" shall mean all of Intermedix's rights in and to the Product and Product Unit, including, without limitation, Intermedix's copyrights, trademarks, trade dress, trade secrets, patents and patent applications (if any), and "know how" and any other proprietary information developed by Intermedix relevant to the Product and/or Product Unit, recognized in any jurisdiction in the world, now or hereafter existing, whether or not registered or registerable.

(c) "Product" shall mean, collectively, each TripTix® Product Unit (a tablet PC, personal digital assistant or similar device), the Software, a third party wireless card in the name of Intermedix and any Third-Party Intellectual Property Rights, as applicable.

(d) "Product Unit" shall mean a single data collection device delivered pursuant to the terms and conditions of this Exhibit D containing one or more elements of the Product but shall not mean any ancillary devices or products provided by persons other than Intermedix.

(e) "Software" means the copies of Intermedix's software programs as are contained in the Product, including any documentation included therewith. Intermedix may, at its sole discretion, provide corrections and modifications to the Software from time to time.

(f) "Third-Party Interface Devices" shall mean those devices that interface with the Product to transfer information, including medical monitoring devices for which Third-Party Intellectual Property Royalty Payments are made.

(g) "Third-Party Intellectual Property Rights" shall mean the Intellectual Property rights of any third-party used in connection with the Product.

(h) "Third-Party Intellectual Property Royalty Payments" shall mean the payments to be made directly by Client or, indirectly, on Client's behalf, as consideration for the licensing of any Third-Party Intellectual Property Rights or use of any Third-Party Interface Devices.

(i) "Users" shall mean: (i) any employees of Client and (ii) any medical professional who is authorized to perform medical services for Client in the area in which Client operates its emergency medical services as of the Addendum Effective Date.

ARTICLE II. PRICE AND PAYMENT

2.01 Adjustment to Rates of Compensation under the Agreement. The compensation due and owing Intermedix by Client shall be increased as described in Section 4.01 of this Exhibit D during the Term. Additionally, in the event that Client terminates this Exhibit D during the period twelve (12) months following the Agreement Effective Date, it shall pay an early termination fee as set out on Schedule 2.01 hereto.

2.02 Product Fees. In addition to the payments required pursuant to the provisions of Section 5 (Compensation and Method of Payment) of the Agreement, Client shall make the following payments: (i) all Third-Party Intellectual Property Royalty Payments as further set out on Schedule 2.02 hereto.

2.03 Additional Services. The additional Services shall be provided to Client at no additional charge, as long as the Agreement is in effect, as set out on Schedule 2.03 hereto. Should the contractual relationship between the parties change, then terms and conditions of the Agreement and Product pricing shall be negotiated between the parties in good faith.

ARTICLE III. RIGHT TO USE PRODUCT AND PROPRIETARY RIGHTS

3.01 Right to Use. Commencing on the Effective Date and subject to the terms and conditions of this Exhibit D, Intermedix grants Client and its Users a non-exclusive, non-transferable right to use the Product during the Term. This right to use the Product during the Term does not constitute a sale of the Product or any portion or piece thereof.

3.02 Delivery and Acceptance. Intermedix will deliver to Client, the Product at mutually agreeable times, after or simultaneously with the Effective Date.

3.03 No Other Rights. Client's rights in the Product will be limited to those expressly granted in this Article III. All changes, modifications or improvements made or developed with regard to the Product by Intermedix, whether or not made or developed at Client's request, shall be and remain the property of Intermedix. Intermedix reserves all Intellectual Property rights and any other rights in and to the Product not expressly granted to Client hereunder.

3.04 Restrictions. Client acknowledges that Intermedix and its suppliers, including, without limitation, the suppliers of certain Third-Party Intellectual Property Rights, have, retain and own all right, title and interest in and to the Product, and all patent, copyright, trademark and service mark and trade name and the goodwill associated therewith, trade secret, inventions, technology, ideas, know-how, and all other intellectual property rights and all other rights pertaining thereto. All such right, title and interest shall be and remain the sole property of Intermedix. Client shall not be an owner of, or have any interest in the Product but rather, such Client only has a right to use the Product pursuant to this Addendum. Neither Client nor its Users shall: (i) remove any copyright, patent or other proprietary legends from the Product; (ii) sub-license, lease, rent, assign, transfer or allow any third-party any right to use the Product; (iii) alter, modify, copy, enhance or adapt any component of the Product; (iv) attempt to reverse engineer, covert, translate, decompile, disassemble or merge any portion of the Product with any other software or materials; (v) otherwise create or attempt to create any derivative works from this Product, or permit persons who are not Users any access to the Product or its operations, and any attempt to do any of the above shall void all warranties given Client by Intermedix and shall be a material breach of this Addendum.

3.05 Material Change to Product. If there is any material change in any rules, orders, laws or regulations governing the manner in which this Product operates or in the data provided by third parties (such as changes in the manner of operation of global distribution systems or standards in wireless or non-wireless communications protocols); then upon written notice to Client, Intermedix will have the right, retroactive to the date of such material change, to modify the way in which this Product delivers data in order to comport with any change in law or regulations or functionality governing the Product. All data used by Intermedix for testing and development shall be supplied by Client at its expense to Intermedix promptly upon request by Intermedix to Client.

ARTICLE IV. PRODUCT UNITS

4.01 Generally. Client and Intermedix understand and agree that Intermedix shall make available one or more Product Units. Client understands and acknowledges that any of the aforementioned Product Units provided by Intermedix will be subject to the additional fee described in Section 2.02 of this Exhibit D. Also, in connection with the potential provision of such Product Units, Client agrees:

4.02 Client will be responsible for any loss or damage to such Product Units. Client agrees to pay:

(a) the cost of repairs in excess of manufacturer extended warranty of any such Product Unit provided to it or (ii), if the Product Unit is irreparable, lost or stolen, for the replacement cost of the Product Unit. Client is responsible for repair or replacement costs not covered by extended warranty provided by Intermedix. Client agrees that Client may obtain insurance for such devices provided that Intermedix is named as a beneficiary under such insurance. Intermedix will use commercially reasonable efforts to provide Client with a replacement Product Unit within one (1) business day following the business day on which the request is made.

(b) Client agrees that it shall immediately (and in no greater than twenty four (24) hours from Client's knowledge of the following) notify Intermedix of any loss or theft of a Product Unit (a "Product Unit Loss Event"). Upon Intermedix's receipt of notification given by the Client of a Product Unit Loss Event, Intermedix shall have the right to immediately, without notice to Client, suspend Client's access to the Product and the Product Unit until such time as the Product Unit Loss Event has been fully resolved, and no longer presents a threat of inappropriate access to: (i) the Product, (ii) any other intellectual property rights of Intermedix or (iii) the personal data or Protected Health Information gathered by Client in the performance of EMS by the Client. To the extent that any Product Unit Loss Event involves Protected Health Information, and is subject to HIPAA, as amended by the HITECH Act, Client shall comply with all applicable requirements under such laws, including any applicable HIPAA Notification requirements triggered by the Product Unit Loss Event. To the extent that a Product Unit Loss Event requires Client to provide HIPAA Notifications, any such notifications shall not include a reference to Intermedix unless such a reference is specifically required by HIPAA or other applicable law. Further, if Client intends to reference Intermedix in a HIPAA Notification based on its belief that such a reference is required by HIPAA or other applicable law, Client shall provide Intermedix written notice of its intent to do so no later than ten (10) days prior to Client's provision of each required HIPAA Notification (i.e. no later than ten (10) days prior to Client's provision of notifications to affected individuals, Health & Human Services, and/or prominent media outlets, as applicable). Client acknowledges that they are responsible for configuring the Product Unit security password configuration (the "Product Unit Security Configuration") and providing that Users provide adequate safeguard password security.

(c) Client may be required to enter into additional agreements with the makers of third-party devices (monitors, scanners, EKG machines, etc.) with respect to the transmission of information between the third party device and the Product Unit. Client understands and agrees that Intermedix will not be able to provide Product Units unless and until agreements are entered into with the third-party manufacturers of such third party devices. Client understands and agrees that its failure to enter into or reach agreements with such third-parties (and any and all consequences of such failure) shall not be deemed to be a default of Intermedix under this Exhibit D or any other arrangement between Client and Intermedix. Client further understands and agrees that the failure to enter into such agreements with these third parties may hinder Client's use of certain software features that might otherwise be available to it (for instance, a direct data connection between a third party device and the Product Unit).

4.03 Client may be required to obtain new or different medical or other equipment capable of communicating with the Product Unit. Client understands and agrees that such new or different medical or other equipment must be obtained at Client's sole cost and expense.

4.04 Client may request Intermedix to support additional medical or other devices. Client understands and agrees that the costs of developing an interface may be significant and may involve the payment of royalties to the third-party manufacturers of the device. Client further understands and agrees that Intermedix has no obligation to undertake the development of interfaces with additional medical or other devices.

4.05 Client agrees to indemnify and hold Intermedix, its agents, and employees harmless from any and all liabilities and costs, and against any claim, suit, fine, or damages, including loss of profits, reasonable attorneys' fees, or interest, or any incidental, indirect, special, or consequential damages incurred as a result of any loss or damage to a Product Unit, the failure to utilize and require that its Users utilize one or more Product Unit Security Configurations which comply with the Billing Security Characteristics, or an actual or alleged violation of local, state or federal laws, including, but not limited to, laws applicable to Medicare, Medicaid, HIPAA, the HITECH Act, or any other public or private Payor or enforcement agency.

ARTICLE V. TERM AND TERMINATION

5.01 Generally. The term of this Exhibit D shall begin on the Effective Date and shall continue the termination or expiration of the Agreement, unless terminated as provided in Section 5.03 below.

5.02 Termination. Notwithstanding any other language herein or in the Agreement, a termination of this Exhibit D shall not operate to terminate the Agreement, but a termination of the Agreement shall operate as a termination of this Exhibit D.

5.03 Termination of Exhibit D.

(a) If Intermedix, at any time, materially fails to perform any obligation required under this Exhibit D, or breaches any material term or condition of this Exhibit D, and such material default or breach, being curable, continues uncured for thirty (30) calendar days after written notice from Client to Intermedix specifying the nature and extent of the failure to materially perform such obligation, Client shall have the right to terminate this Exhibit D upon the expiration of said thirty (30) calendar day period, without any obligation to pay any early termination payment outlined in Schedule 2.01.

(b) If Client, at any time, fails to materially perform any obligation required under this Exhibit D, or breaches any material term or condition of this Exhibit D, and such material default or breach, being curable, continues uncured for thirty (30) calendar days after written notice from Intermedix to Client specifying the nature and extent of the failure to materially perform such obligation, Intermedix shall have the right to terminate this Addendum upon the expiration of said thirty (30) calendar day period, and any early termination payment required by Client outlined in Schedule 2.01 shall be immediately due and payable to Intermedix.

(c) Termination without Cause. Client may terminate this Exhibit D (but not the Agreement) at any time without cause by providing thirty (30) calendar days prior written notice to Intermedix, and making payment in full of the required early termination payment disclosed on Schedule 2.01 with respect to each Product Unit delivered pursuant to this Exhibit D, which shall be immediately due and payable as of the date of such written notice of termination. As of the effective date of such termination, Client shall return all Product Units to Intermedix and shall have no further right to access the Product provided hereunder.

(d) Intermedix may terminate this Exhibit D at any time without cause upon six (6) months prior written notice to Client.

(e) Obligations Following Termination. Any termination of this Exhibit D shall not release Client or Intermedix from any claim of the other accrued hereunder prior to the effective date of such termination. Upon termination of this Exhibit D, Intermedix shall remain the sole owner of the Product and all Intellectual Property and goodwill associated therewith, and Client shall assert no rights thereto. Upon termination of this Exhibit D for any reason, Client shall immediately discontinue use of the Product, and within ten (10) calendar days, return each of the Product Units and certify in writing to Intermedix that all copies, extracts or derivatives of any item comprising the Product, in whole or in part, in any form, have either been delivered to Intermedix or destroyed in accordance with Intermedix's instructions. All payments made by Client to Intermedix hereunder are non-refundable.

ARTICLE VI. LIMITED WARRANTY AND DISCLAIMER:

6.01 Product Warranty. Intermedix warrants that each Product Unit delivered to Client will be free from material defects when delivered.

6.02 Information/Disclaimer of Warranties with Respect to Data and Information Provided by Third Parties. Some information transmittable or accessible through any Product Unit may have been obtained through sources believed to be reliable (such as various Internet providers, real-time data provided by GPS systems or medical devices or other third party information sources). Client agrees that Intermedix shall not have any liability whatsoever for the accuracy, completeness, timeliness or correct sequencing of the information, or for any decision made or action taken by Client in reliance upon such information or the Product. Client further agrees that Intermedix shall have no liability whatsoever for the transmission, non-transmission or partial transmission of data through third-party data systems and that such transmission shall be undertaken at Client's sole risk, cost and expense.

6.03 Disclaimer. Intermedix and its third party suppliers do not warrant that any Product will meet Client's requirements or that access to the Product, or the operation of the Product, will be uninterrupted, error-free, that all errors will be timely corrected, or that the data and/or reports generated by the Product will be accurate in the event that any third party information providers have provided inaccurate information. THE WARRANTIES EXPRESSLY PROVIDED IN THIS EXHIBIT D AND THE AGREEMENT ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR NON-INFRINGEMENT, WHICH WARRANTIES ARE HEREBY

SPECIFICALLY DISCLAIMED. NO REPRESENTATIVE OF INTERMEDIX SHALL HAVE THE RIGHT TO MAKE WARRANTIES ON INTERMEDIX'S BEHALF UNLESS THOSE WARRANTIES ARE IN WRITING AND EXECUTED BY A DULY AUTHORIZED OFFICER OF INTERMEDIX.

6.04 Exclusive Remedy. For any breach of the warranties set forth in Section 6.01, Intermedix, shall, following written notice thereof by Client, use diligence efforts, at Intermedix's sole expense, promptly to repair or replace the nonconforming Product or Product Unit. This is Intermedix's sole and exclusive liability, and Client's sole and exclusive remedy, for the breach of the above warranties. Intermedix shall have no obligation to replace any defective Product Unit which is not returned to Intermedix immediately following delivery or which has failed because of accident, abuse or misapplication.

Schedule 2.01
Early Termination Fee

The Initial Term Early Termination Payments with respect to each Product Unit are as follows:

	Period	Amount
(1)	For an Early Termination during the first twelve (12) months from the beginning of the Term:	$4,300.00
(2)	For an Early Termination during the remainder of the Term:	$0.00

Schedule 2.02
Third-Party Intellectual Property Royalty Payments

In addition to the other compensation required under this Exhibit D, Third-Party Intellectual Property Payments shall be made as follows:

Licensing/Royalty agreement to be executed between Client and the manufacturer of Client's defibrillating equipment when the manufacturer has cleared the Product Unit for direct interface between their equipment and Intermedix provided data devices.

Schedule 2.03

Additional Services

(1) Client has purchased TripTix product pursuant to the terms and conditions of this Exhibit D and Intermedix shall provide TripTix based reporting extract of data required by state or local regulatory authorities' connectivity/interface in a format reasonably required by such authorities.

(2) Provide training to Client for use of TripTix ePCR product meeting minimum requirements for the TripTix implementation of; (i) three (3) calendar days of on-site training using the Train-the-Trainer format, and; (ii) followed by two to three (2-3) WebEx sessions for the purpose of Administrative training and potentially one (1) additional TripTix training.

(3) Provide an interface to Client's Computer-Aided Dispatch ("CAD") system for the purpose of supplying to the TripTix software dispatch information in a format suitable as prescribed by Intermedix. Client agrees to pay any charges for this purpose as required by its CAD vendor and that Intermedix is not responsible for such charges, nor is Intermedix responsible for any lack of cooperation by the Client's CAD vendor in attempting to develop such interface for client. Should Client change CAD Vendor or substantially change CAD software version after initial implementation, Client shall be responsible for costs to implement the new CAD interface.