



CITY OF HOLLYWOOD, FLORIDA

PROCUREMENT SERVICES DIVISION

Piggybacking Request Form

(Use for purchase(s) over \$25,000, when piggybacking off other contracts)

Date 6/1/2021

Department/Office Fire

Division/Area EMS

Contract Administrator Mark Miller

Title Deputy Chief

Phone 954-967-4248

Email mmiller@hollywoodfl.org

1. Requested Vendor Change Healthcare

Vendor Number _____

Address 5995 Windward Parkway Alpharetta, GA 30005

Contact Person Mauricio Chavez

Title Specialty Vice President, EMS

Phone 305-970-2780

Email
mauricio.chaves@changehealthcare.com

2. Contract title requesting to piggyback? EMS Ambulance Billing and Electronic Patient Care Reporting Services (EPCR)

Awarding Agency City of Lauderhill

Contract Expiration Date 8/2023

Copy of Contract and Awarding Agency documentation is attached.

☒ Yes ☐ No

3. Product/Service being requested (be specific). EMS Ambulance Billing and Electronic Patient Care Reporting Services (EPCR) to include all Hardware and software with support.

Procurement Service Division use only

Requisition # R
(As Applicable)

Purchase Order # P
(As Applicable)

Blanket Purchase Order # BPO
(As Applicable)

4. Detailed description of the products/services function and purpose. Change Healthcare will provide billing services for all of our EMS transports. In addition to providing the hardware, software and service for both EMS and fire reports.

5. Please explain what process the Department/Office took to verify and/or identify this contract. Market research

6. Were alternative contracts evaluated to determine that the City is obtaining the most advantageous contract pricing for the required product/service?

☒ Yes ☐ No

Please explain The Finance department did a side by side compairson of our current billing company vs. Change Healthcare. Change Healthcare provides the service needed at a lesser cost along with hardware and software support.

7. Total cost of the requested product/service. 9.6% of net collections

8. Total estimated annual (fiscal year) cost of requested product/service. \$361,000.00

Account Number(s) 001.215001.52200.631170. 000000.000.000 invoiced monthly

9. Is this product/service covered by a warranty? ☒ Yes ☐ No

If yes, please attach a copy of the warranty details.

10. Would this purchase(s) result in the potential of future purchases for related products/services being restricted to a particular vendor or create a specific vendor as sole source provider for related items?

☐ Yes ☒ No

If yes, please describe the related products/services and estimated cost(s.) _____

11. Would this purchase(s) result in any future maintenance costs which are not included in the initial purchase?

☐ Yes ☒ No

If yes, please attach a draft maintenance plan which includes cost estimates and funding source(s.) _____

12. Is this a grant related purchase? ☐ Yes ☒ No

If yes, please provide details (timeline, expiration dates, milestones, special procurement requirements, etc.) _____

Will this require matching funds? ☐ Yes ☒ No

What is the grant source? _____

What is the grant (dollar) amount? _____

Procurement Service Division use only

Requisition # R _____
(As Applicable)

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(As Applicable)

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(As Applicable)

Date of Advanced Search 6/1/2020

Company Name(s) Searched
Change Healthcare

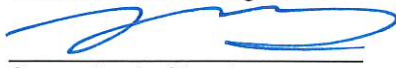
Search Results
N/A

REQUESTING DEPARTMENT RECOMMENDATION


Note: By signing and returning this form, you are verifying and acknowledging that you have reviewed all portions (scope, terms, conditions, pricing, etc.) of the requested contract and recommend its approval based on the contract complying with the City of Hollywood's scope and pricing requirements and to the best of you knowledge the contract does not violate any applicable policy, statute, governing rule or regulation.


Contact Person's Signature

6-1-2021
Date


Supervisor's Signature

6-1-2021
Date


Director's Signature

6-1-2021
Date

APPROVAL (Procurement Service Division Use Only)			
Verified By:		Date	
Approved By:		Date	

Procurement Service Division use only

Requisition # R
(As Applicable)

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