Insert name of Proposed Physician Reviewer

Offeror Name

Corporate Offeror Name

Corporate Offerors add Company Name

INS Mcare 2008-01

RFP Response Template
for

TECHNICAL

A response to the TECHNICAL portion of the RFP is REQUIRED.

Carefully read each question and follow the instructions provided.

Initial each page
of your printed RFP
to indicate your review of each page.

Initial Page

Please provide a response to the following statement:

II.5. TAB 4. Work Plan. Explain your approach to accomplish the tasks of the physician reviewer requested in Part IV of this RFP, principally which physician will provide the physician reviewer services and the reasons why this physician reviewer may be expected to provide high quality services.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.5. TAB 4
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.5. TAB 4. ~ Please continue to II.6. TAB 5.a.

Initial Page

II.6. TAB 5. Prior Experience. Experience shown should be work done by the individual physician who will be assigned to this project (i.e., the proposed physician reviewer), as well as that of Offeror's company if the Offeror is not an individual physician. Responses to the following statements will provide the necessary information from which the RFP Evaluation Committee will score and qualify the Offeror. All statements must be addressed.

Please provide a response to the following statement:

a. Describe for the proposed physician reviewer the work, if any, performed as a physician for Commonwealth of Pennsylvania state agencies. State the circumstances/terms of the contracts, etc. under which you perform work for the named state agency. As explained in Part I of this RFP, work performed as a physician for Commonwealth of Pennsylvania state agencies does not necessarily disqualify an Offeror.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.a.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.a. ~ Please continue to II.6. TAB 5.b.

Initial Page

Please provide a response to the following statement:

b. Indicate for the proposed physician reviewer:

(Assume that a full-time physician in direct patient care has at least forty (40) hours of patient care scheduled per week.)

i) the total number of years he practiced full-time in direct patient care

ii) the total number of years he practiced part-time in direct patient care

iii) the number of years since the physician last provided direct patient care

Please provide a response to the following statement:

If the individual physician being proposed to provide the physician reviewer services has not provided direct patient care in the last ten (10) years, explain how this physician has remained current with the standard of care.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.b.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.b. ~ Please continue to II.6. TAB 5.c.

Initial Page

Please provide a response to the following statement:

c. Attach a resume of the proposed physician reviewer's career experience, education, training, publications, and jobs previously held in the field of medicine or related to work to be performed. Include the specific dates of each activity, the hours of effort and the proposed physician reviewer's role.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.c.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.c. ~ Please continue to II.6. TAB 5.d.

Initial Page

Please provide a response to the following statement:

d. Provide a statement outlining the proposed physician reviewer's prior experience in performing the specific tasks requested under this contract, including identification of individuals or entities for which work was performed and that this work was provided to claims representatives, as well as specify dates of the experience, the hours of effort and the physician reviewer's role.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.d.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.d. ~ Please continue to II.6. TAB 5.e.

Initial Page

Please provide a response to the following statement:

e. Provide a statement regarding the proposed physician reviewer's prior experience reviewing and rendering written opinion in medical professional liability claims for a medical professional liability insurance carrier, excess insurance fund or self-insured health care provider.

Include a count or estimate of the number of cases reviewed for which the individual physician being proposed to provide the physician reviewer services analyzed the care and himself produced a written report, as well as the dates when these efforts started and ceased. If this work was for various entities, indicate the quantity of work and dates for each.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.e.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.e. ~ Please continue to II.6. TAB 5.f.

Initial Page

Please provide a response to the following statement:

f. Explain the extent to which the proposed physician reviewer's analysis and rendering of written opinion in medical professional liability claims for a medical professional liability insurance carrier, excess insurance fund or self-insured health care provider where the analysis and reports were provided to claims representatives for purpose of education and comprehensive analysis of the medical issues involved in a medical malpractice case, including recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claims.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.f.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.f. ~ Please continue to II.6. TAB 5.g.

Initial Page

Please provide a response to the following statement:

g. State which of the physician specialties the proposed physician reviewer is or was Board certified or Board eligible of the following categories of physician specialties sought under this RFP (i.e., 1) OB/GYN, 2) Internal Medicine and 3) General Surgery or Thoracic Surgery).

☐ OB/GYN ☐ General Surgeon ☐ Thoracic Surgeon ☐ Internal Medicine

This completes your response to II.6. TAB 5.g. ~ Please continue to II.6. TAB 5.h. below.

Please provide a response to the following statement:

h. Indicate whether the proposed physician reviewer proposes to work regularly in Mcare's Harrisburg office, Rosemont office, or both?

☐ Harrisburg ☐ Rosemont ☐ Both

This completes your response to II.6. TAB 5.h. ~ Please continue to II.6. TAB 5.i.

Initial Page

Please provide a response to the following statement:

i. Provide a statement explaining the proposed physician reviewer's prior experience in rendering of review and written opinion to a claims representative for purpose of education and comprehensive analysis of the medical issues involved in a medical malpractice case involving the physician specialty or specialties this physician is proposed to provide in this proposal, including the standard of care rendered to a patient, the validity of defense and plaintiff expert opinion, causation review and recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claim.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.i.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.i. ~ Please continue to II.6. TAB 5.j.

Initial Page

Please provide a response to the following statement:

j. Attachment a statement indicating that the proposed physician reviewer designated in Offeror's proposal has reviewed and personally authored at least one-hundred (100) unique written opinions in medical professional liability claims for a medical professional liability insurance carrier, excess insurance fund or self-insured health care provider where the analysis and reports were provided to claims representatives for purpose of education and comprehensive analysis of the medical issues involved in medical malpractice cases that were pending at the time of the review, including recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claims.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.j.
Place attachment(s) directly behind this printed page.

☐

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.j. ~ Please continue to II.6. TAB 5.k.

Please provide a response to the following statement:

k. Attach a minimum of ten (10) samples of redacted high quality written opinions authored by the proposed physician reviewer for claims representatives for purpose of education and comprehensive analysis of the medical issues involved in medical malpractice cases, including the standard of care rendered to a patient, the validity of defense and plaintiff expert opinion, causation review and recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claim. These opinions and reports will be evaluated by the RFP Evaluation Committee in terms of whether the written report analyzed and communicated effectively to claims representatives:

i) the standard of care rendered to a patient substantiated by accepted medical standards pertinent to the time, place and specialization of medical care that has been rendered;

ii) the validity of defense expert opinion;

iii) plaintiff expert opinion; and,

iv) causation review.

These reports should evidence the proposed physician reviewer having previously prepared for use in medical professional liability claims for an insurance provider for the purpose of education and comprehensive analysis of the medical issues involved in a medical malpractice case, including recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claims. Additional comments appended to some or all of the reports that may be helpful in determining the context and scope of the samples submitted are encouraged.

If the provision of sample reports is not possible, the Offeror shall state the reason for not fulfilling this requirement and provide a alternate method to enable the RFP Evaluation Committee to evaluate the proposed physician reviewer's skills and experience in analyzing and authoring high quality written opinions for claims representatives for purpose of education and comprehensive analysis of the medical issues involved in medical malpractice cases.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.k.
Place attachment(s) directly behind this printed page.

This completes your response to II.6. TAB 5.k. ~ Please continue to II.6. TAB 5.l.

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Initial Page

Please provide a response to the following statement:

l. Provide a statement as to whether or not the proposed physician reviewer designated in Offeror's proposal is or has been licensed as a physician for at least eight (8) years and has been employed for at least two (2) years to analyze and render written opinions in medical professional liability claims for a medical professional liability insurance carrier, excess insurance fund or self-insured health care provider where the analysis and reports were provided to claims representatives for purpose of education and comprehensive analysis of the medical issues involved in medical malpractice cases that were pending at the time of the review, including recommendations on specialties of expert review to be secured to assist in the defense of medical malpractice liability claims.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.l.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.l. ~ Please continue to II.6. TAB 5.m

Initial Page

Please provide a response to the following statement:

m. Provide a statement regarding the level of experience and proficiency the proposed physician reviewer in all aspects of reviewing, comprehending and determining the policy and administration of acute care facilities (including individual departments), long term care facilities, psychiatric inpatient and outpatient facilities, physician office practices, podiatry practices, certified nurse practitioner practices, birth centers, primary care centers and other types of health care delivery systems, for a health care provider or an insurance provider.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.m.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.m. ~ Please continue to II.6. TAB 5.n.

Please provide a response to the following statement:

n. Provide a statement regarding the proposed physician reviewer's experience and proficiency in all aspects of rendering comprehensive, written medical opinion on the quality of medical care rendered in specialized areas including, but not limited to, family practice, emergency medicine, general medicine, general surgery, thoracic medicine, neurology, neurosurgery, obstetrics, gynecology, pulmonary medicine, pediatrics, internal medicine, orthopedics, vascular surgery, nursing, psychiatry, rehabilitative medicine, geriatrics, long term care medicine.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5n.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.n. ~ Please continue to II.6. TAB 5.o.

Initial Page

Please provide a response to the following statement:

o. Provide a statement regarding the extent of the proposed physician reviewer's knowledge of health management organizations, physician provider organizations and physician corporations, sufficient to determine involvement in the issues surrounding a medical incident.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.o.
Place attachment(s) directly behind this printed page.

☐

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.o. ~ Please continue to II.6. TAB 5.p.

_____
Initial Page

Please provide a response to the following statement:

p. Provide a statement regarding the extent of the proposed physician reviewer's knowledge of providers of medical professional liability coverage for physicians, hospitals, nursing homes, podiatrists, certified nurse practitioners, birth centers, primary care centers and other types of health care delivery systems.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.p.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.p. ~ Please continue to II.6. TAB 5.q

Initial Page

Please provide a response to the following statement:

q. Provide a statement or evidence of the ability of the proposed physician reviewer to communicate in English, for both oral and written communication, complex medical issues to non-medical persons in a succinct and understandable fashion.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.q.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.q. ~ Please continue to II.6. TAB 5.r.

Initial Page

Please provide a response to the following statement:

r. List and describe each and every instance in which the proposed physician reviewer in the last ten (10) years functioned as an expert witness in a medical professional liability claim or case on behalf of attorneys, insurance companies, contract administrators and physicians.

Include in the list and description the client's name, address, type of business, contact person, telephone number, period of time, the type and scope of services provided, the number of hours and role in each instance, and case title.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.r.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.r. ~ Please continue to II.6. TAB 5.s.

Initial Page

Please provide a response to the following statement:

s. Attach evidence of board certification or board eligibility in at least one of the fields of obstetrics/gynecology, internal medicine, general surgery or thoracic surgery.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.s.
Place attachment(s) directly behind this printed page.

This completes your response to II.6. TAB 5.s. ~ Please continue to II.6. TAB 5.t.

Please provide a response to the following statement:

t. Provide a statement of the proposed physician reviewer's current or previous staff privileges to practice medicine and admit patients to an acute care facility.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.t.
Place attachment(s) directly behind this printed page.

☐

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.t. ~ Please continue to II.6. TAB 5.u.

Initial Page

Please provide a response to the following statement:

u. Provide a statement or evidence of participation in on-going medical training as required by the Pennsylvania state board of licensure.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.u.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.u. ~ Please continue to II.6. TAB 5.v.

Initial Page

Please provide a response to the following statement:

v. State for the proposed physician reviewer the total number of years he taught medicine and surgery, the number of hours and role he taught.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.v.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.v. ~ Please continue to II.6. TAB 5.w.

Please provide a response to the following statement:

w. Provide a minimum of two professional references and one personal reference, including name, address, company and telephone number.

#1 Professional Reference:

Name | Phone Number

Company

Address

City | State | Zip Code

#2 Professional Reference:

Name | Phone Number

Company

Address

City | State | Zip Code

Personal Reference:

Name | Phone Number

Company (Not Req'd)

Address

City | State | Zip Code

If your response requires additional space, follow the "Attachment Instructions" to submit a complete response.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.w.
Place attachment(s) directly behind this printed page.

This completes your response to II.6. TAB 5.w. ~ Please continue to II.6. TAB 5.x.

Initial Page

Please provide a response to the following statement:

x. Provide a statement(s) disclosing all potential conflicts of interest, including specific financial interests and relationships and affiliations relevant to the services to be provided under this RFP. Offerors should err on the side of full disclosure and should contact the Issuing Officer if they have questions or concerns.

Examples of conflicts include a physician reviewer who:

i) Participated in the development or execution of the treatment plan under review;

ii) Is or was an associate or close competitor of the health care provider under review;

iii) Is or was a member of the family of the health care provider under review;

iv) Is or was actively practicing in the same hospital or nursing facility as a physician, certified nurse midwife or podiatrist under review;

v) Is or was a governing body member, officer, partner, owner, employee, employer, contractor or subcontractor of the health care provider under review.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page the following:
1) Offeror Name and 2) II.6. TAB 5.x.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.x. ~ Please continue to II.6. TAB 5.y.

Initial Page

Please provide a response to the following statement:

y. Provide a list and describe each and every instance in which the Offeror or proposed physician reviewer is one of the following or had a financial relationship with a physician, certified nurse midwife, podiatrist, nursing home, hospital, birth center and primary care center licensed by the Commonwealth of Pennsylvania and entities providing medical professional liability insurance, including brokers and producers.

Financial relationships include making or accepting *non-de minimis* gifts, loans, debts, severance payment, real estate interests, annuities, stock, contracts, bonds, employment arrangements, and assets transferred to immediate family members. Include in the list and description the name, address, type of business, contact person, telephone number, period of time, and the type and scope of services provided.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.y.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.y. ~ Please continue to II.6. TAB 5.z.

Initial Page

Please provide a response to the following statement:

z. Provide a list and describe each and every instance in which the Offeror or proposed physician reviewer provides or in the last ten (10) years has provided the same or similar types of services to be provided under a contract to be awarded this RFP, including the number of hours and role in each instance, such as sixty percent (60%) of full-time.

Include in the list and description the client's name, address, type of business, contact person, telephone number, period of time, and the type and scope of services provided.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.z.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.z. ~ Please continue to II.6. TAB 5.aa.

Initial Page

Please provide a response to the following statement:

aa. Provide a list and describe each and every instance in which the Offeror or the proposed physician reviewer practiced direct patient care medicine and surgery in the last ten (10) years, including the number of hours and role in each instance, such as sixty percent (60%) of full-time.

Include in the list and description the client's name, address, type of business, contact person, telephone number, period of time, and the type and scope of services provided.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.aa.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.aa. ~ Please continue to II.6. TAB 5.bb.

Initial Page

Please provide a response to the following statement:

bb. Provide a list and describe each and every instance in which the Offeror or the proposed physician reviewer taught medicine or surgery in the last ten (10) years, including the number of hours and role in each instance, such as sixty percent (60%) of full-time.

Include in the list and description the client's name, address, type of business, contact person, telephone number, period of time, and the type and scope of services provided.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.bb.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.bb. ~ Please continue to II.6. TAB 5.cc.

Initial Page

Please provide a response to the following statement:

cc. Provide a list and describe each and every instance in which the proposed physician reviewer functioned as an expert witness in a medical professional liability claim or case on behalf of attorneys, insurance companies, contract administrators and physicians in the last ten (10) years.

Include in the list and description the client's name, address, type of business, contact person, telephone number, period of time, the type and scope of services provided, the number of hours and role in each instance, and case title.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.6. TAB 5.cc.
Place attachment(s) directly behind this printed page.

RESPONSE INSTRUCTIONS:

Type or write your response in the space provided below.

If your response requires additional space, follow the above "Attachment Instructions" to submit a complete response.

This completes your response to II.6. TAB 5.cc. ~ Please continue to II.6. TAB 5.dd.

Initial Page

Please provide a response to the following statement:

dd. Affirm that the proposed physician reviewer will perform the following listed tasks. Each task is to be individually referenced/acknowledged:

i)	Report to the work location on demand and make themselves accessible for contact and receipt of work assignments when off site during business hours of 8:30 AM to 5:00 PM, Monday through Friday.	☐ I Affirm
ii)	Agree to be physically present in the Mcare office location assigned (state preference on location) a minimum of 1 day per week designated by Mcare management and to be present at claims committee meetings as required by Mcare management.	☐ I Affirm
iii)	Agree to travel throughout the state, primarily near the cities of Harrisburg and Philadelphia, as needed.	☐ I Affirm
iv)	Receive assignments for case review from Mcare examiners or management and prepare written, comprehensive reports in a short time frame. Deadlines for opinions and written reports are often between one and seven days.	☐ I Affirm
v)	Agree to be accessible for telephone or personal conference each business day on an urgent basis.	☐ I Affirm
vi)	Agree to perform the necessary research in order to render substantiated medical opinions on requested cases.	☐ I Affirm
vii)	As requested, provide a written report on the care rendered by each involved treating health care provider by specific specialty. The report shall address each involved health care provider by caption. If plaintiff and/or defense expert reports have been provided for review, the report shall specifically address the physician reviewer's opinion on the validity of the position stated by the expert. Reporting format may vary based upon request by the referring examiner.	☐ I Affirm
viii)	Be physically present at and participate to the extent required, at a scheduled claim review meetings a minimum of once per business week for no less than 3 hours.	☐ I Affirm

Please continue your response to II.6. TAB 5.dd. on the next page...

Initial Page

Please continue your response to II.6. TAB 5.dd.

ix) Conduct or participate in training sessions geared to educate Mcare claims staff as requested. ☐ I Affirm

x) Conduct or participate in training sessions geared to educate various groups within the medical community, such as residents, physicians, nurses, or health care facility administration on issues of medical risk management, medical aspects of professional liability claims or other issues as deemed necessary by Mcare management. ☐ I Affirm

xi) Agree to attend other meetings as deemed necessary by Mcare management. ☐ I Affirm

This completes your response to II.6. TAB 5.dd. ~ Please continue to II.9. TAB 8.

II-9. TAB 8. Objections and Additions to Standard Contract Terms and Conditions. The Offeror will identify which, if any, of the terms and conditions (contained in **Appendix A**) it would like to negotiate and what additional terms and conditions the Offeror would like to add to the standard contract terms and conditions. The Offeror's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Issuing Office may consider late objections and requests for additions if to do so, in the Issuing Office's sole discretion, would be in the best interest of the Commonwealth. The Issuing Office may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Offeror shall not request changes to the other provisions of the RFP, nor shall the Offeror request to completely substitute its own terms and conditions for **Appendix A**. All terms and conditions must appear in one integrated contract. The Issuing Office will not accept references to the Offeror's, or any other, online guides or online terms and conditions contained in any proposal. Regardless of any objections set out in its proposal, the Offeror must submit its proposal, including the cost proposal, on the basis of the terms and conditions set out in **Appendix A**. The Issuing Office will reject any proposal that is conditioned on the negotiation of the terms and conditions set out in **Appendix A or to other provisions of the RFP as specifically identified above**.

Please provide a response to the following statement:

◯ No Objections — If no objections is selected, proceed to APPENDIX B.

◯ Objections noted below — If objections is selected, attach a statement noting objections and then proceed to APPENDIX B.

ATTACHMENT INSTRUCTIONS:

☐ **Click** the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
1) Offeror Name and 2) II.9. TAB 8.
Place attachment(s) directly behind this printed page.

This completes your response to II.9. TAB 8. ~ Please continue to APPENDIX B.

Initial Page

COMPLETION of this FORM is REQUIRED and must be included with your TECHNICAL response.

APPENDIX B - PROPOSAL COVER SHEET

COMMONWEALTH OF PENNSYLVANIA
Department of Insurance
Office of Medical Care Availability and Reduction of Error Fund
INS Mcare 2008-01

Enclosed in separately sealed submittals is the proposal of the Offeror identified below for the above-referenced RFP:

Name of Proposed Physician Reviewer	
Offeror Mailing Address	
Corporate Offeror's Name	
Offeror's Website (if applicable)	
Offeror's Contact Person	
Contact Person's Phone Number	
Contact Person's Fax Number	
Contact Person's E-Mail Address	
Corporate Offeror's Federal ID Number	
Proposed Physician Reviewer's PA Medical License Number	

Indicate below the Submittals Enclosed and Separately Sealed in Envelopes:

- ☐ Technical (Required)
- ☐ Mandatory Requirements for Proposal Check List (Required)
- ☐ Cost (Required)
- ☐ Disadvantaged Business (Optional)

SIGNATURE

Signature of Offeror. If Offeror is a Company, an official authorized to bind the Offeror to the provisions in the Offeror's proposal:

Name _____ Title _____

FAILURE TO COMPLETE, SIGN AND RETURN THIS FORM WITH OFFEROR'S PROPOSAL MAY RESULT IN THE REJECTION OF THE OFFEROR'S PROPOSAL.

This completes your response to APPENDIX B. ~ Please continue to APPENDIX C.

Initial Page

COMPLETION of this FORM is REQUIRED and must be included with your TECHNICAL response.

Appendix C

NONCOLLUSION AFFIDAVIT

INS Mcare 2008-01

State of _____ :
: S.S.
County of _____ :

I state that I am _____ of

Name of Firm, if applicable _____

and that I am authorized to make this affidavit on behalf of myself, or if applicable on behalf of my firm, and its owners, directors, and officers. I am the person responsible (in my firm, if applicable) for the price(s) and the amount of this bid.

I state that:

(1) The price(s) and amount of this bid have been arrived at independently and without consultation, communication or agreement with any other contractor, bidder or potential bidder.

(2) Neither the price(s) nor the amount of this bid, and neither the approximate price(s) nor approximate amount of this bid, have been disclosed to any other firm or person who is a bidder or potential bidder, and they will not be disclosed before bid opening.

(3) No attempt has been made or will be made to induce any firm or person to refrain from bidding on this contract, or to submit a bid higher than this bid, or to submit any intentionally high or noncompetitive bid or other form of complementary bid.

(4) The bid of my firm is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive bid.

(5) (Name of Offeror and Corporate Offeror if applicable)

_____

its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by an governmental

_____
Initial Page

agency and have not in the last four years been convicted or found liable for any act prohibited by state or federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract, except as follows:

I stated that (**Name of Offeror**) _____ understands and acknowledges that the above representations are material and important, and will be relied on by the Department of Insurance in awarding the contract(s) for which this bid is submitted. I understand and my firm understands that any misstatement in this affidavit is and shall be treated as fraudulent concealment from the Purchasing Agency of the true facts relating to the submission of this bid.

_____ (Signature)

_____ (Print Signatory's Name)

_____ (Print Signatory's Title)

SWORN TO AND SUBSCRIBED

BEFORE ME THIS _____ DAY

OF _____ 2008.

_____ Notary Public

My Commission Expires _____

This completes your response to APPENDIX C. ~ Please continue to next page.

This completes your response to the TECHNICAL portion of the RFP.

PLEASE CONTINUE TO THE NEXT PAGE AND FOLLOW THE

"TECHNICAL SUBMISSION INSTRUCTIONS"

Initial Page

"TECHNICAL SUBMISSION INSTRUCTIONS"

Technical Submission Requirement as stated in PART II. Please read carefully and follow the instructions:

a. Technical submittal, which shall be in response to RFP II-3. TAB 2 through and including II-9. TAB 8.

Submission Requirements:

i) All TABs must contain a response.
   1) If TAB is not applicable, state "not applicable" as your response.

ii) Include signed Proposal Cover Letter (Appendix B)

iii) **PRINT** your response then Copy ten (10) sets.
- A set must contain one complete copy of the responses, including appropriately marked attachments, to the entire TECHNICAL portion of the RFP, for a total of 10 sets.
- (9 plus one copy marked "Original" for a total of 10)

iv) Response to RFP Section **II-6, TAB 5**. **Prior Experience** shall state the name of the proposed physician reviewer on the first (1st) page of each separate redacted written report. If Offeror is a corporate entity, add corporate name.

v) The preferred submission manner is to place a set of the entire TECHNICAL portions into 10 separately tabbed 3-ring binders.
   1) Acceptable alternative:
      a) Separately staple each TAB's response,
      b) Attach either a binder clip or a rubber band to keep all the responses, including attachments, to the entire TECHNICAL portion of the RFP, bundled together.

vi) Place the binders or bundled materials in a separate envelope with the following text noted on the outside of the envelope:
TECHNICAL
INS Mcare 2008-01
OFFEROR NAME
(If Offeror is a corporate entity, add proposed physician reviewer name.)

vii) Seal envelope.

Optional Submission Requirements if Needed:

viii) If the TECHNICAL submittal requires more than one (1) separately sealed envelope, the Offeror shall add the following text on the outside of each additional Technical submittal envelope to indicate the total number of envelopes included as the TECHNICAL submittal:
TECHNICAL - x of y
INS Mcare 2008-01
OFFEROR NAME
(If Offeror is a corporate entity, add proposed physician reviewer name.)

ix) Seal all envelopes.

This completes your response to the TECHNICAL portion of the RFP.

ELECTRONIC SUBMISSIONS WILL NOT BE ACCEPTED.

Initial Page

Continue to the next page to begin the COST portion of your response.

Initial Page

Insert name of Proposed Physician Reviewer

Offeror Name

Corporate Offeror Name

Corporate Offerors add Company Name

INS Mcare 2008-01

RFP Response Template
for

COST

This begins your response to the COST portion of the RFP which is REQUIRED.

Carefully read each question and follow the instructions provided.

Initial each page
of your printed RFP
to indicate your review of each page.

Initial Page

II-11. TAB 10. Cost Submittal. The information requested in this tab shall constitute the **Cost** Submittal.

The **Cost** submittal shall be placed in a separate sealed envelope within the sealed proposal, separated from the technical submittal and all other sections as outlined in II-1.d.

The total proposed cost shall be broken down into the following components:

Please provide a response to the following statement:

a. Provide an hourly rate that will remain the same for the first 3 years. Hourly Rate:

b. Provide a proposed hourly rate that will be applicable if the renewal option is exercised. The hourly rate will remain the same for years 4 and 5 and will be negotiated, but in no case will the rate be more than 110% of the base rate. Hourly Rate

Offeror will only be paid the hourly rate for the physician reviewers actual hours appropriately invoiced, aside from reimbursement for parking and any travel or continuing medical education and professional membership expenses authorized by the Contract Officer.

No travel time will be reimbursed.

Only the physician reviewer's hourly rate in the first 3 years will be considered in measuring and evaluating the "cost" of an Offeror's proposal.

Offerors should **not** include any assumptions in their cost submittals. If the Offeror includes assumptions in its cost submittal, the Issuing Office may reject the proposal.

Offerors should direct in writing to the Issuing Officer pursuant to **Part I, Section I-10**, of this RFP any questions about whether a cost or other component is included or applies. All Offerors will then have the benefit of the Issuing Office's written answer(s) so that all proposals are submitted on the same basis.

The Issuing Office will reimburse the selected Offeror for work satisfactorily performed after execution of a written contract and the start of the contract term, in accordance with contract requirements, and only after the Issuing Office has issued a notice to proceed.

This completes your response to the COST portion of the RFP, unless you complete and submit the Optional II.2. TAB 11. Domestic Workforce Utilization Certification .

PLEASE SEE THE "COST SUBMISSION INSTRUCTIONS" LOCATED ON PAGE 44.

Initial Page

II-12. TAB 11. Domestic Workforce Utilization Certification. If applicable, complete and sign the Domestic Workforce Utilization Certification contained in **Appendix E** of this RFP. Offerors who seek consideration for this criterion must submit in hardcopy the signed Domestic Workforce Utilization Certification Form in the same sealed envelope with the Cost Submittal.

Continue to next page to complete the optional Domestic Workforce Utilization Certification.

COMPLETION of this FORM is OPTIONAL.
If completed, must be included with your COST response.

APPENDIX E
DOMESTIC WORKFORCE UTILIZATION CERTIFICATION

Each proposal will be scored for its commitment to use the domestic workforce in the fulfillment of the contract. Maximum consideration will be given to those offerors who will perform the contracted direct labor exclusively within the geographical boundaries of the United States. Those who propose to perform a portion of the direct labor outside of the United States will receive a correspondingly smaller score for this criterion.

In order to be eligible for any consideration for this criterion, offerors must complete and sign the following certification. This certification will be included as a contractual obligation when the contract is executed. Failure to complete and sign this certification will result in no consideration being given to the offeror for this criterion.

I, _____**[title]** of _____[name of **Contractor]** a _____ **[place of incorporation]** corporation or other legal entity, ("Contractor") located at _____ _____**[address],** having a Social Security or Federal Identification Number of _____, do hereby certify and represent to the Commonwealth of Pennsylvania ("Commonwealth") (Check **one** of the boxes below):

☐ All of the direct labor performed within the scope of services under the contract will be performed exclusively within the geographical boundaries of the United States.

OR

☐ _____ **percent (_____%) [Contractor must specify the percentage]** of the direct labor performed within the scope of services under the contract will be performed within the geographical boundaries of the United States. Please identify the direct labor performed under the contract that will be performed outside the United States:

_____

☐ ***ATTACHMENT INSTRUCTIONS:*** **Click** the **CHECK BOX** if your response includes an attachment(s). Each attachment must state on at least page 1 the following: 1) Offeror Name and 2) Appendix E. Place attachment (s) directly behind this printed page.

The Department of General Services **[or other purchasing agency]** shall treat any misstatement as fraudulent concealment of the true facts punishable under Section 4904 of the *Pennsylvania Crimes Code*, Title 18, of Pa. Consolidated Statutes.

Attest or Witness:

_____
Corporate or Legal Entity's Name

_____
Signature/Date

_____
Signature/Date

_____
Printed Name/Title

_____
Printed Name/Title

This completes your response to APPENDIX E. ~ Please continue to NEXT PAGE.

_____
Initial Page

"COST SUBMISSION INSTRUCTIONS"

COST Submission Requirement as stated in PART II. Please read carefully and follow the instructions:

Cost Submittal, in response to RFP **II-11, TAB 10.** The Offeror shall provide one (1) PRINTED copy**.** If your response includes **II-12. TAB 11 Domestic Workforce Utilization Certification** Form located in Appendix E, one **(1)** PRINTED copy signed must be enclosed with Cost Submittal.

Submission Requirements:

i) Place in a separate envelope with the following text noted on the outside of the envelope:
Disadvantaged Business Information Participation
RFP INS Mcare 2008-01
OFFEROR NAME
(If Offeror is a corporate entity, add proposed physician reviewer name.)

ii) Seal envelope.

This completes your response to the COST portion of the RFP.

ELECTRONIC SUBMISSIONS WILL NOT BE ACCEPTED.

This completes your response to the COST portion of the RFP, unless you complete and submit the Optional II.10. TAB 9. Disadvantaged Business Information Participation, found on next page.

Initial Page

Insert name of Proposed Physician Reviewer

Offeror Name

Corporate Offeror Name

Corporate Offerors add Company Name

INS Mcare 2008-01

RFP Response Template
for

DISADVANTAGED BUSINESS INFORMATION PARTICIPATION

This begins your response to the

DISADVANTAGED BUSINESS INFORMATION PARTICIPATION

portion of the RFP which is OPTIONAL.

Carefully read each question and follow the instructions provided.

Initial each page
of your printed RFP
to indicate your review of each page.

Initial Page

II-10. TAB 9. Disadvantaged Business Submittal.

a. **Disadvantaged Business Information.**

i) To receive credit for being a Small Disadvantaged Business or a Socially Disadvantaged Business or for entering into a joint venture agreement with a Small Disadvantaged Business or for subcontracting with a Small Disadvantaged Business (including purchasing supplies and/or services through a purchase agreement), an Offeror must include proof of Disadvantaged Business qualification in the Disadvantaged Business Submittal of the proposal, as indicated below:

1) A Small Disadvantaged Businesses certified by BMWBO as an MBE/WBE must provide a photocopy of their BMWBO certificate.

2) Small Disadvantaged Businesses certified by the U.S. Small Business Administration pursuant to Section 8(a) of the *Small Business Act* (15 U.S.C. § 636 (a)) as an 8(a) or small disadvantaged business must submit proof of U.S. Small Business Administration certification. The owners of such businesses must also submit proof of United States citizenship.

3) All businesses claiming Small Disadvantaged Business status, whether as a result of BMWBO certification or U.S. Small Business Administration certification as an 8 (a) or small disadvantaged business, must attest to the fact that the business has 100 or fewer employees.

4) All businesses claiming Small Disadvantaged Business status, whether as a result of BMWBO certification or U.S. Small Business Administration certification as an 8 (a) or small disadvantaged business, must submit proof that their gross annual revenues are less than $20,000,000 ($25,000,000 for those businesses in the information technology sales or service business). This can be accomplished by including a recent tax return or audited financial statement.

ii) All businesses claiming status as a Socially Disadvantaged Business must include in the Disadvantaged Business Submittal of the proposal clear and convincing evidence to establish that the business has personally suffered racial or ethnic prejudice or cultural bias stemming from the business person's color, ethnic origin or gender. The submitted evidence of prejudice or bias must:

1) Be rooted in treatment that the business person has experienced in American society, not in other countries.

2) Show prejudice or bias that is chronic and substantial, not fleeting or insignificant.

3) Indicate that the business person's experience with the racial or ethnic prejudice or cultural bias has negatively impacted his or her entry into and/or advancement in the business world.

BMWBO shall determine whether the Offeror has established that a business is socially disadvantaged by clear and convincing evidence.

iii) In addition to the above verifications, the Offeror must include in the Disadvantaged Business Submittal of the proposal the following information:

1. The name and telephone number of the Offeror's project (contact) person for the Small Disadvantaged Business.

2. The business name, address, name and telephone number of the primary contact person for each Small Disadvantaged Business included in the proposal. The Offeror must specify each Small Disadvantaged Business to which it is making commitments. The Offeror will not receive credit for stating that it will find a Small Disadvantaged Business after the contract is awarded or for listing several businesses and stating that one will be selected later.

3. The specific work, goods or services each Small Disadvantaged Business will perform or provide.

4. The estimated dollar value of the contract to each Small Disadvantaged Business.

5. Of the estimated dollar value of the contract to each Small Disadvantaged Business, the percent of the total value of services or products purchased or subcontracted that will be provided by the Small Disadvantaged Business directly.

6. The location where each Small Disadvantaged Business will perform these services.

7. The timeframe for each Small Disadvantaged Business to provide or deliver the goods or services.

8. The amount of capital, if any, each Small Disadvantaged Business will be expected to provide.

9. The form and amount of compensation each Small Disadvantaged Business will receive.

10. For a joint venture agreement, a copy of the agreement, signed by all parties.

11. For a subcontract, a signed subcontract or letter of intent.

iv) The Offeror is required to submit only **one** copy of its Disadvantaged Business Submittal. The submittal shall be clearly identified as Disadvantaged Business information and sealed in its own envelope, separate from the remainder of the proposal.

v) The Offeror must include the dollar value of the commitment to each Small Disadvantaged Business in the same sealed envelope with its Disadvantaged Business Submittal. The following will become a contractual obligation once the contract is fully executed:

1) The amount of the selected Offeror's Disadvantaged Business commitment;

2) The name of each Small Disadvantaged Business; and

3) The services each Small Disadvantaged Business will provide, including the timeframe for performing the services.

vi) A Small Disadvantaged Business can be included as a subcontractor with as many prime contractors as it chooses in separate proposals.

vii) An Offeror that qualifies as a Small Disadvantaged Business and submits a proposal as a prime contractor is not prohibited from being included as a subcontractor in separate proposals submitted by other Offerors.

b. **Enterprise Zone Small Business Participation.**

i) To receive credit for being an enterprise zone small business or entering into a joint venture agreement with an enterprise zone small business or subcontracting with an enterprise zone small business, an Offeror must include the following information in the Disadvantaged Business Submittal of the proposal:

1) Proof of the location of the business' headquarters (such as a lease or deed or Department of State corporate registration), including a description of those activities that occur at the site to support the other businesses in the enterprise zone.

2) Confirmation of the enterprise zone in which it is located (obtained from the local enterprise zone office).

3) Proof of United States citizenship of the owners of the business.

4) Certification that the business employs 100 or fewer employees.

5) Proof that the business' gross annual revenues are less than $20,000,000 ($25,000,000 for those businesses in the information technology sales or service business). This can be accomplished by including a recent tax return or audited financial statement.

6) Documentation of business organization, if applicable, such as articles of incorporation, partnership agreement or other documents of organization.

ii) In addition to the above verifications, the Offeror must include in the Disadvantaged Business Submittal of the proposal the following information:

1) The name and telephone number of the Offeror's project (contact) person for the Enterprise Zone Small Business.

2) The business name, address, name and telephone number of the primary contact person for each Enterprise Zone Small Business included in the proposal. The Offeror must specify each Enterprise Zone Small Business to which it is making commitments. The Offeror will not receive credit for stating that it will find an Enterprise Zone Small Business after the contract is awarded or for listing several businesses and stating that one will be selected later.

3) The specific work, goods or services each Enterprise Zone Small Business will perform or provide.

4) The estimated dollar value of the contract to each Enterprise Zone Small Business.

5) Of the estimated dollar value of the contract to each Enterprise Zone Small Business, the percent of the total value of services or products purchased or subcontracted that each Enterprise Zone Small Business will provide.

6) The location where each Enterprise Zone Small Business will perform these services.

7) The timeframe for each Enterprise Zone Small Business to provide or deliver the goods or services.

8) The amount of capital, if any, each Enterprise Zone Small Business will be expected to provide.

9) The form and amount of compensation each Enterprise Zone Small Business will receive.

10) For a joint venture agreement, a copy of the agreement, signed by all parties.

11) For a subcontract, a signed subcontract or letter of intent.

iii) The dollar value of the commitment to each Enterprise Zone Small Business must be included in the same sealed envelope with the Disadvantaged Business Submittal of the proposal. The following will become a contractual obligation once the contract is fully executed:

1) The amount of the selected Offeror's Enterprise Zone Small Business commitment;

2) The name of each Enterprise Zone Small Business; and

3) The services each Enterprise Zone Small Business will provide, including the timeframe for performing the services.

This completes your response to the Disadvantaged Business Information Participation portion of the RFP.

ELECTRONIC SUBMISSIONS WILL NOT BE ACCEPTED.

Initial Page

PLEASE THE "DISADVANTAGED BUSINESS INFORMATION PARTICIPATION SUBMISSION INSTRUCTIONS"

Disadvantaged Business Information Participation Submittal, in response to RFP Section **II-10, TAB 9, and** the Offeror shall provide two (2) sets.

Submission Requirements:

i) The **Disadvantaged Business Information Participation** need not be bound.

ii) **PRINT** your response then Copy two (2) sets.

- A set must contain one complete copy of the responses, including attachments if required, to the entire **Disadvantaged Business Information Participation** portion of the RFP, for a total of two (2) sets.

iii) Place in a separate envelope with the following text noted on the outside of the envelope:
Disadvantaged Business Information Participation
RFP INS Mcare 2008-01
OFFEROR NAME
(If Offeror is a corporate entity, add proposed physician reviewer name.)

iv) Seal envelope.

Initial Page

INS Mcare 2008-01

RFP Response Template
for
APPENDIX F

Offeror's Information That is Relevant, But Not Applicable to Enumerated Categories in the RFP

This Appendix is OPTIONAL.
If completed it should be submitted with your TECHNICAL response.

Initial the page
of your printed RFP
to indicate your review of this page IF COMPLETED.

Continue to next page to complete the Optional Appendix F.

Initial Page

This Appendix is OPTIONAL.

APPENDIX F

Offeror's Information That is Relevant, But not Applicable to Enumerated Categories in the RFP

As stated in **II - Proposal Requirements**, Offerors must submit their proposals in the format, including heading descriptions, outlined below. To be considered, the proposal must respond to all requirements in this part of the RFP.

Offerors should provide any other information thought to be relevant, but not applicable to the enumerated categories, in Appendix F to the Proposal.

ATTACHMENT INSTRUCTIONS:

Click the **CHECK BOX** if your response includes an attachment(s).
Each attachment must state on at least page 1 the following:
☐ 1) Offeror Name and 2) Appendix F.
Place attachment(s) directly behind this printed page
AND
Place at the END of your **TECHNICAL** response.

This completes your Response to the:

TECHNICAL (Required)

COST (Required)

DISADVANTAGED BUSINESS PORTION (Optional)

portions of the RFP.

BE SURE TO COMPLETE THE
MANDATORY REQUIREMENTS FOR PROPOSAL Check List
template located on Mcare's RFP website.

NOTE: THAT YOU STILL MUST **SUBMIT PRINTED** COPIES OF
YOUR RFP RESPONSE AS PROVIDED IN THE RFP.

Initial Page

Submit Form