

**UCLA HEALTH SYSTEM
Request for Information #7146**

**Process Improvement, Root Cause Analysis for Denial Reduction & Interim
Department Leadership in Patient Access & Patient Financial Services (Billing)**

INTENT TO RESPOND NOTICE

This page must be completed and signed below by an authorized company representative and returned to indicate acceptance of the terms and conditions of the UCLA Health System Request for Information and the company's intent to submit a proposal.

Name of Company:

Company Representative/Title:

Phone Number including area Code:

Fax Number including area code:

Email Address:

Signature of authorized representative:

Electronic scanned versions of this signed notification will be accepted by the due date at the following email address:

Email:tmoseley@mednet.ucla.edu