



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

Department of Corrections

DIVISION OF ADMINISTRATIVE SERVICES
Anchorage Procurement Section

550 W. 7th Avenue, Suite 1800

Anchorage, AK 99501

Phone: 907.269.7352

Fax: 907.269.7345

Email: mary.lockwood@alaska.gov

August 22, 2014

To: Vendor List

Re: **Amendment #3 – Return Acknowledgement Required**
Request for Proposals, RFP #2015-2000-2477
Medical Laboratory Testing Services, Statewide

Dear Vendor:

In response to questions received, the Department of Corrections has made a modification to the RFP's Cost Proposal Form that affects how pricing is submitted, and additionally provides clarification with regard to acceptable "test names" for two line items listed on the cost form as follows:

Question:

Item 35, Serum HCG Qualitative & Quantitative. These are two separate tests with two separate CPT codes. Do you want vendors to price them separately, or should vendors enter a total price by combining both tests together?

Reply:

The DOC requires separate pricing for each test. Attachment #1 has been modified to reflect this change by separating Item 35 into two lines numbered 35(a) and 35(b) and assigned estimated quantities to each.

Question:

Item 23, CD-V Count: This test name has changed to "Lymphocyte Subset Panel"

Reply:

The DOC has inserted the updated name on the enclosed Modified Cost Proposal Form. Proposals referencing either of these test names will be acceptable.

Question:

Item 25, HBV-Core IgM + IgG: May this test also be referred to as "HBV Core Ab Total"?

Reply:

Yes, both names are acceptable.

MODIFICATIONS TO THE REQUEST FOR PROPOSALS

Attachment #1, Cost Proposal Form is hereby deleted and replaced by
Attachment #1, Modified Cost Proposal Form (enclosed)

Because Amendment #3 institutes a mandatory additional proposal requirement that affects how costs are proposed, vendors must acknowledge receipt of this amendment. Failure to do so may cause their proposal to be rejected. This can be done by completing the information at the bottom of this page and returning it to the procurement officer not later than the proposal deadline, or otherwise acknowledging receipt within their submitted proposal document.

END OF AMENDMENT #3

Sincerely,

Mary Lockwood

Procurement Specialist II

Enclosure: Modified Cost Proposal Form (2 pages)

Vendor Acknowledgement for Receipt of Amendment #3:

Signature

Date

Printed name and title: _____

Agency name: _____

Attachment 1**MODIFIED COST PROPOSAL FORM
RFP # 2015-2000-2477**

Offerors must use this form, or an equivalent format, to enter data that will be utilized to determine the cost per test for provision of services. All proposed costs (including personnel, direct, indirect, any travel and/or implementation costs, etc.) must be included in the per test costs. The following sample service requirement quantities will be used for *cost evaluation purposes only* and are not to be considered the expected annual workload. Pricing is required for every item on the entire listing. The prices as specified in Attachment 1 (or negotiated per sec. 2.17) will be binding on the offeror for the periods of service covered by this RFP. (See RFP sec. 1.07 for required review by vendors, and 1.08 for question submission procedures.)

Page 1 of 2

ITEM NO.	TEST NAME	CPT CODE	EST. TESTS PER/YR	COST PER TEST	COST OF LINE ITEM
	General-Standard-Misc				
1	Comprehensive Metabolic Panel	80053	1,750		
2	CBC-Diff-Plt Ct	85025	2,050		
3	Urinalysis	81000	275		
4	Lipid Profile (with HDL)	80061	850		
5	Partial Thromboplastin Time	85730	25		
6	Prothrombin Time w/ INR	85610	200		
7	Amylase	82150	75		
8	Ammonia	82140	25		
9	Iron Profile (Fe, Transferrin, % Sat)	83540	15		
10	H. Pylori IgG	86677	10		
11	H. Pylori breath test	83013	10		
12	Vitamin B-12 Level	82607	50		
13	Anti-Nuclear Antibody (ANA)	86038	10		
14	Liver function test	80076	100		
15	Prenatal Panel	80055	100		
16	Quad sScreen (maternity)	n/a	5		
17	CBC (H/H, RBC, WBC, PLT)	85027	450		
18	Hepatic Function Panel	80076	68		
19	Basic Metabolic Panel	80048	74		
20	Electrolyte Panel	80051	12		
	HIV-Related				
21	HIV-ELISA	86703	25		
22	HIV-RNA Quantitative	87536	25		
23	Lymphocyte Subset Panel/CD4 count	84436	25		
	Hepatitis-Related				
24	Acute Hepatitis Profile	80074	50		
25	HBV-Core IgM + IgG		25		
26	HBsAg	87340	75		
27	RPR	86592	75		
28	HCV-ELISA	86803	25		
	Endocrine Related				
29	Hemoglobin A1-C	83036	450		
30	Glucose	82947	75		
31	Urine Microalbumin	82043	75		
32	Thyroid Stimulating Hormone	84443	750		
33	T3	84479	81		
34	T4	84436	39		
35 (a)	Serum HCG, Qualitative	84703	50		
35 (b)	Serum HCG, Quantitative	84702	25		
36	Prolactin	84146	50		

Page 2 of 2					
ITEM NO.	TEST NAME	CPT CODE	# TESTS PER/YR	COST PER TEST	COST OF LINE ITEM
	Drug Levels				
37	Diphenylhydantoin	80185	75		
38	Valproic Acid	80164	300		
39	Lithium	80178	250		
40	Carbamazepine	80156	100		
41	Amitriptyline	80152	10		
42	Digoxin	80162	10		
43	Serum Drug Screen *	80100	50		
44	Urine Drug Screen *	80100	50		
	Tumor Markers				
45	Alpha Feto-Protein	82105	200		
46	CEA	82378	15		
47	Prostate Specific Antigen	84153	150		
	Microbiology				
48	Urine Culture & Sensitivity	81001	350		
49	Throat Culture	87070	10		
50	Culture, aerobic/aner	87070	250		
51	Culture, aerobic bac		100		
TOTAL COST OF PROPOSAL (for evaluation purposes)				\$	

* Items 43-44: Drug screens consist of the following: amphetamines; THC; cocaine, opiates; barbiturates.

ADDITIONAL PROPOSAL INFORMATION REQUIRED

In addition to the completed cost proposal form above, offerors must provide a complete listing of their current client fee schedule showing all lab tests available, and the cost for each. If offered, indicate the percentage discount, for the additional tests not specified in the Cost Proposal Form above that will be available to the DOC. (Any discounts taken under a contract resulting from this solicitation for the available tests not listed above will be calculated based on the contractor's Client Fee Schedule that is in effect at the time of service provision.) Either enter the discount amount, or zero if none offered:

AMOUNT OF DISCOUNT OFFERED: _____ %

If proposed, indicate any extra per test fee for STAT services (see Section 5.01(f):

When requested by DOC, STAT testing for services will be performed at an additional \$ _____ charge per test.

Vendor Name: _____

Authorized Signature

Date