MIX NETWORKS

Healthcare Sales Playbook

POTS Replacement + Hosted Voice for Physician Groups, ASCs, Clinics, Dialysis & Imaging Chains, and Medical Office Buildings

Buyer Map | Compliance Triggers | Objection Matrix | Outreach Sequences | Discovery Scripts | Proposal Template

July 2026 | Internal Sales & Channel Enablement | Pricing per MSRP Guide updated 5/29/26

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1. Why Healthcare, Why Now

Healthcare is the fax capital of the American economy and one of its densest analog-line environments. Referrals, prior authorizations, lab orders, prescriptions, and records requests still move by fax; vaccine refrigerators, blood banks, medical-gas systems, and generators are monitored by analog dialers; and every multi-story medical office building carries fire panels and elevator phones on carrier copper. The vertical spans a huge addressable base — solo practices to hospital systems — but the sweet spot for this play is the **multi-site outpatient middle**: physician groups (3–20 locations), ambulatory surgery centers, dialysis and imaging chains, urgent care networks, FQHCs, and the medical office buildings that house them.

Why the timing works:

- **The copper deadline is universal.** AT&T began decommissioning copper wire centers in June 2026, with TDM discontinuance filings effective on or after November 15, 2026 across 18 states and 90-day customer notice. Healthcare copper lines at $100–$200/month are climbing while the clinical workflows riding on them — fax above all — are not going anywhere on any realistic timeline.
- **Compliance pressure comes from three enforcers at once.** HIPAA governs every fax and every stored page image; the CMS Emergency Preparedness Rule requires certified providers (hospitals, ASCs, dialysis facilities, FQHCs, hospice, and more) to document primary AND alternate communication methods; and accreditation surveys (Joint Commission, AAAHC, and peers) test emergency communications and life-safety systems. All three point at the same aging copper.
- **Missed calls are missed revenue with clinical consequences.** An unanswered scheduling call is a lost appointment and often a lost patient; a failed after-hours on-call path is a patient-safety and liability event. Hosted Voice with queues, on-call routing, and recording addresses both — and healthcare practices measure phone performance more readily than most SMBs because no-show and referral-leakage math is already on the administrator's dashboard.
- **Multi-site operators standardize.** Dialysis chains, urgent care networks, dental service organizations, and PE-backed physician platforms actively consolidate vendors as they acquire. One management services organization (MSO) win can be a 10–50 site rollout on one MSA.

The MIX advantage in one paragraph

MIX Networks is a Managed Facilities-based Voice Network (MFVN) provider delivering POTS-IN-A-BOX (DataRemote 90X1/90X2) — UL 864 (10th Ed.) compliant, California State Fire Marshal listed (Listing No. 7305-2384:0002), FDNY MFVN-recognized (Record ID 2025-TMFRAL-007143-VRNC), NFPA 72-aligned with dual pathways (WAN + 4G/5G), up to 48-hour battery backup, and 24/7 proactive monitoring — plus an enterprise-grade secure fax platform supporting HIPAA technical safeguards (TLS encryption, authenticated portals, protected storage, audit-ready delivery confirmation) and turnkey managed installation documented line by line. The combination matters: most POTS replacement vendors cannot speak to fax compliance, and most cloud-fax vendors cannot touch a fire panel. MIX walks in owning both conversations.

2. Buyer Map

Healthcare buying authority tracks the operating model. Independent practices close with the practice administrator and a physician owner. MSO/PE-backed platforms and chains close at corporate ops/IT. ASCs close with the administrator plus the facilities-responsible party. MOBs close with property management. Identify the model before the first call — the same clinic looks completely different depending on who owns it.

Role	What They Own	What They Care About	Lead With	Deal Role
Practice Administrator / COO	Operations, vendors, budget across the group's locations	Phones answered, referrals not leaking, staff efficiency, predictable costs, audits passed	Free line audit + missed-call assessment; fax that stops being a compliance worry	Economic buyer (independent groups)
Physician Owner / Managing Partner	The practice itself; final say on material contracts	Liability, patient experience, distributions — not telecom	One-page risk-and-savings summary the administrator hands them; peer references	Ratifier
MSO / Corporate VP Ops or IT	Standards across acquired practices; integration playbooks	Vendor consolidation, day-one integration of acquisitions, per-site economics at scale	Standardized per-site package with add-a-site pricing; one MSA, one invoice, portfolio dashboard	Economic buyer (platforms/chains)
ASC Administrator	The surgery center: accreditation, CMS conditions, daily ops	Passing CMS/accreditation surveys, EP plan documentation, zero OR-day disruption	EP-plan-grade dual-path comms; life-safety cert package; install scheduled around OR days	Economic buyer (ASC)
Compliance / Privacy Officer	HIPAA program, risk assessments, BAAs, incident response	PHI in transit, vendor risk, audit trails, breach exposure	Secure fax architecture: encryption, authentication, storage controls, delivery audit; full security documentation for their vendor review	Gatekeeper — win them early
IT Director / MSP	Network, EHR connectivity,	Not babysitting new devices,	Fully managed platform with 24/7 monitoring; cellular	Technical gatekeeper / channel ally

Role	What They Own	What They Care About	Lead With	Deal Role
	phones (often outsourced)	QoS, EHR uptime, who to call at 2am	path independent of clinic internet; MSP co-exists, does not compete	
Facilities / Property Manager (MOB, hospital)	Fire panels, elevators, building systems, inspections	Passing fire and elevator inspections across the building/campus	AHJ-ready cert package; NFPA 72 Ch. 14 retest coordinated; one monitored platform per building	Champion / source of truth
Front Office / Clinic Managers	Site-level phones, fax, scheduling	Lines that work, faxes that arrive, fewer angry patients	Site-level pains feed the audit; they know where every fax machine is	Influencers / intel source
Director of Nursing / Clinical Ops	Clinical workflows, pharmacy/lab communications	Orders arriving, results back fast, on-call reachability	Secure fax reliability + on-call routing on Hosted Voice	Influencer (clinical)

Access strategy

- **Independent groups (3–20 sites):** call the practice administrator; the office manager at the busiest site is the warm path in. Avoid Mondays and first-of-month; mid-week 1–3pm is the scheduling lull.
- **MSO / PE platforms and chains:** target VP Ops and IT at corporate with the standardization story; acquisitions are the trigger — every new practice they buy inherits a telecom mess they must integrate.
- **ASCs:** the administrator wears every hat; lead with survey-readiness and OR-calendar-respecting installation. State ASC associations are a dense, reachable community.
- **MOB owners/managers:** one building = fire panel + elevators + dozens of tenant suites. Sell the building infrastructure to the property manager, then walk tenant suites with their blessing — the property manager becomes a referral channel into every tenant.
- **Channel multipliers:** healthcare MSPs and EHR consultants own the IT relationship but not the analog/life-safety problem — they are natural agent partners, not competitors. MGMA chapters and state ASC/medical group associations are the conference circuit.

3. Compliance Triggers

Healthcare has more enforcers per square foot than any other vertical: HIPAA/OCR, CMS conditions of participation, accreditation bodies, the fire AHJ, the elevator inspector, and the practice's own malpractice carrier. Precision is non-negotiable — compliance officers are professional skeptics, and one overstated claim ends the relationship.

3.1 HIPAA and the Fax Problem — the Healthcare-Specific Wedge

- **The trigger:** fax remains the default transport for referrals, prior auths, lab orders and results, prescriptions, and records requests. Analog fax on copper offers no encryption, no authentication, no audit trail — and misdirected faxes are a recurring breach category. Every practice has a fax horror story; every compliance officer knows the machines are the soft underbelly of their HIPAA risk assessment.
- **The MIX answer:** enterprise-grade secure fax — TLS-encrypted transfer, authenticated web portals, protected document storage, audit-ready delivery confirmation, redundant infrastructure with intelligent routing and automatic retries. Deployment flexibility matters clinically: cloud fax (no machine, no line), on-premise ATA (existing machines and staff workflows unchanged), hybrid, and Email-to-Fax/Fax-to-Email with print-to-fax drivers. Fax-enabled users at $5.95/mo; services at $15.95–$16.95/mo.
- **Say it precisely:** the platform *supports HIPAA technical safeguards when configured with proper access controls and retention policies.* Do not say “HIPAA certified” (no such thing exists) and do not freelance on Business Associate Agreement terms — route BAA questions to MIX contracting with the compliance officer directly. Offering that meeting proactively is itself a credibility move.

3.2 CMS Emergency Preparedness Rule

- **The trigger:** CMS-certified providers — hospitals, ASCs, ESRD/dialysis facilities, FQHCs, hospice, home health, and more — must maintain an Emergency Preparedness program with a communication plan reviewed regularly, identifying primary and alternate modes of communication. Surveyor guidance is explicit that a facility cannot rely solely on one telephone system that may fail. Dialysis facilities feel this hardest: patients must be located and rescheduled within hours of a closure, not days.
- **The MIX answer:** dual-path transport (broadband primary, 4G/5G secondary), up to 48-hour battery, 24/7 monitoring, and Hosted Voice off-premises survivability (site dark → calls reroute to mobiles or sister sites). Deliver the architecture summary formatted as an exhibit for the facility's EP communication plan — an artifact the administrator hands the surveyor.
- **Precision note:** MIX does not make a facility “EP Rule compliant” — the program belongs to the facility. MIX provides the redundant communications infrastructure the plan documents. Same discipline as the fax language.

3.3 Fire Alarm Communications — NFPA 72 / UL 864

- **The trigger:** ASCs, MOBs, imaging centers, and any purpose-built medical facility carry fire alarm panels dialing central stations over copper DACT lines. Hospitals and ASCs are additionally surveyed against Life Safety Code requirements as CMS conditions. Copper retirement severs the monitoring path; in an accredited surgical facility that is a survey finding with teeth.

- **The MIX answer:** 90X1/90X2 satisfy 2016 NFPA 72 Ch. 26.6 (MFVN pathway — panel operates unchanged) and exceed NFPA 72 (2025) technical requirements: dual pathways, UL 864 (10th Ed.), UL 62368-1, UL 2054, standby power monitoring, 48-hour battery. CSFM Listing No. 7305-2384:0002 and FDNY MFVN recognition (Record ID 2025-TMFRAL-007143-VRNC) close the credibility question. Final approval rests with the AHJ; NFPA 72 Ch. 14 retest coordinated by MIX at cutover — volunteer both points.

3.4 E-911 — Kari's Law and RAY BAUM'S Act

- Multi-line phone systems must support direct 911 with on-site notification (Kari's Law) and deliver dispatchable location — building, floor, suite — to the PSAP (RAY BAUM'S Act). A 911 call from exam room 14 of a 60,000 sq ft MOB that presents only the building's main address is the failure these laws target. Hosted Voice provisions direct 911, front-desk notification, and per-suite/per-room location. Strongest with MOBs, large clinics, and ASCs.

3.5 Clinical Monitoring Circuits — the Hidden Line Count

- Vaccine refrigerator/freezer alarms (VFC program participants take temperature excursions seriously — a spoiled vaccine inventory is a five-figure loss plus program scrutiny), blood bank and lab freezer alarms, medical-gas manifold alarms, generator monitoring, dialysis water-treatment alarms, panic buttons at behavioral health sites, elevator phones in MOBs, and the ATM in the lobby. Analog, copper, replaceable on the same 90X2 — and each one the practice forgot it was paying for.

3.6 Compliance Trigger Quick Card

System at the Facility	Governing Standard / Enforcer	Forcing Event	MIX Answer
Referral/lab/Rx fax	HIPAA / OCR; compliance officer	Risk assessment; misdirected-fax incident; payer audit	Secure fax w/ encryption, authentication, storage controls, delivery audit
EP communication plan	CMS EP Rule / CMS surveyor; accreditor	Survey cycle; post-outage findings; drills	Dual-path + 48-hr battery documented as the alternate-comms exhibit
Fire alarm panel (DACT)	NFPA 72, LSC / AHJ; CMS (ASC, hospital)	Copper retirement notice; failed inspection	MFVN path; UL 864 10th Ed.; CSFM + FDNY listings; Ch. 14 retest coordinated
Suite-level 911	Kari's Law, RAY BAUM'S Act / FCC	Phone system change; MOB tenant audit	Hosted Voice w/ direct 911 + dispatchable location
Vaccine/lab/blood refrigeration alarms	VFC program; CLIA/lab standards; insurer	Temperature excursion; inventory loss	Specialty alarm lines on 90X2 w/ battery + cellular failover
Elevator phones (MOB)	ASME A17.1 / elevator inspector	Annual inspection; dead line	Voice & Elevator lines $19.95–$34.95/mo;

System at the Facility	Governing Standard / Enforcer	Forcing Event	MIX Answer
			elevator FXS engineering

4. Line Inventory: Where the Copper Hides

Healthcare sites hide lines in clinical closets no telecom auditor ever visits. Practices that have been acquired once or twice are carrying orphaned lines from every previous owner. The audit finds them — and in healthcare, the audit also builds the fax map that feeds the secure-fax attach.

Zone	Likely Analog Lines	Typical Count
Front office / registration	Main-line remnants on old PBX trunks, scheduling overflow lines, credit card/POS	2–4 per site
Clinical core	Referral fax, lab orders/results fax, Rx fax, EHR-era modem leftovers	2–5 per site
Med storage / lab	Vaccine fridge/freezer alarm dialers, lab freezer alarms, blood bank alarms (ASC/hospital)	1–3 per site
Plant & building (ASC/MOB)	Fire alarm panel (2), elevator phone(s), sprinkler supervisory, generator monitoring, medical-gas alarms	3–7 per building
Security & access	Burglar alarm, panic buttons, door/gate entry, after-hours drop	1–3 per site
Business office	Billing fax, records-request fax, postage meter, ATM line	1–3 per site
Specialty (dialysis/imaging)	Water treatment alarms, equipment telemetry/service modems, magnet monitoring (MRI)	1–3 per site

Rule of thumb: 3–6 specialty lines per clinic site, 6–12 per ASC or MOB. A 7-site physician group yields 20–30 POTS replacement lines, 30–60 hosted seats, and a fax estate begging for consolidation — three products, one audit.

5. Solution Packaging and Deal Math

5.1 The Three-Product Motion

- **Wedge — POTS Replacement (POTS-IN-A-BOX):** one 90X2 (4G/LTE, 8 FXS) or 90X1 (5G, 8 FXS) per site at the demarc; fax machines, alarm dialers, and panels operate unchanged; broadband primary, cellular secondary; fixed per-line term pricing.
- **Attach — Secure Fax (lead attach in this vertical):** in healthcare the fax conversation is not an add-on — it is often the door-opener. Virtual fax $15.95/mo, ATA-based (workflows unchanged) $15.95–$16.95/mo, fax-enabled users $5.95/mo, Fax ATA $100 one-time. The compliance officer who buys the fax story pulls the rest of the deal through.
- **Expansion — Hosted Voice:** seats $14.95/mo; auto attendants; scheduling queues with overflow; after-hours/on-call routing; compliant call recording; UCFone $6.95/user for providers and on-call staff; direct 911 with dispatchable location; Yealink hardware amortized; managed QoS router $15/mo with LTE failover $30/mo.

5.2 Reference Deal: 7-Site Physician Group (6 Clinics + 1 ASC)

Assumptions: 20 specialty lines (fire panel x2 at ASC, elevator at ASC's MOB, 8 fax, 4 fridge/security alarms, 3 modem/telemetry, 2 misc voice), one 90X2 per site, 36-month term. MSRP reference pricing, updated 5/29/26.

Component	Qty	Unit (36 mo)	Monthly
Specialty line — Fax/Modem/Alarm/Data	14	$39.95	$559.30
Specialty line — Voice & Elevator	6	$24.95	$149.70
PIAB 90X2 hardware (amortized)	7	$12.00	$84.00
90X2 maintenance	7	$6.00	$42.00
POTS replacement subtotal			$835.00/mo
vs. copper at $100–$200/line x 20 lines			$2,000–$4,000/mo
Indicative monthly savings			$1,165–$3,165 (58–79%)

One-time: provisioning/staging/kitting $45 per device; site survey and installation at $165/hour (2-hour minimum) per site, quoted per Statement of Work. At 60 months, line rates drop to $29.95/$19.95.

5.3 Reference Deal: Add Hosted Voice + Secure Fax

Component	Qty	Unit	Monthly
User seats (features, DID, user)	40	$14.95	$598.00
Auto attendants (per site)	7	$14.95	$104.65

Component	Qty	Unit	Monthly
UCFone mobile/desktop (providers, on-call, admins)	12	$6.95	$83.40
QoS router monitoring & management	7	$15.00	$105.00
4G LTE failover (basic)	7	$30.00	$210.00
Peplink B One Plus license (InControl)	7	$9.00	$63.00
Yealink T54W phones (36-mo amortized)	40	$7.80	$312.00
Fax-enabled users (via MIX Portal)	14	$5.95	$83.30
Hosted Voice + Fax subtotal			$1,559.35/mo

Combined group MRR: roughly $2,394/month — at or below current copper spend alone for most 7-site groups, while adding compliant fax, EP-grade redundancy, on-call routing, and suite-level 911. The administrator's framing: **one recovered referral or two saved appointment slots per site per month pays the delta; the compliance file improves either way.**

6. Objection Matrix

Objection	What It Really Means	Response
“HIPAA — we can't have another vendor touching PHI.”	The compliance officer doing their job. This is a qualification signal, not a block.	“Exactly the right question. The fax platform encrypts in transit, authenticates every portal user, controls storage, and logs delivery — we will walk your compliance officer through the full security architecture and documentation, including the business associate discussion with our contracting team. Compare that with the analog machine in your hallway printing PHI for whoever walks past.”
“Fax is going away — everything is moving to the EHR / Direct messaging.”	True in theory for fifteen years and counting.	“When your referral partners, payers, and pharmacies all stop faxing, you win and you cancel. Until then the question is whether the faxing you do every day is encrypted, logged, and off copper that is being retired. We make today's reality compliant while interoperability catches up — no forklift either way.”
“Our IT company / MSP handles all of this.”	Lane confusion; the MSP owns the network, not the analog estate.	“Ask them two questions: who owns the fire panel and fridge-alarm lines, and what is their plan for the copper retirement notices? Most MSPs are relieved when we take the analog and life-safety layer — we manage and monitor it 24/7, they keep the network and EHR. We work alongside MSPs constantly; happy to brief them directly.”
“We can't risk any disruption — we see patients all day.”	Legitimate; clinics have no summer break.	“The install model is built for occupied clinics: staging and provisioning happen before anything ships, the physical cutover is scheduled for your lightest block — early morning, lunch, or after last patient — and existing fax machines and alarm equipment do not change. Every line is tested and documented before the copper is released. ASCs: we schedule around OR days, full stop.”
“Cellular isn't reliable enough for a fire alarm / fridge alarm.”	Facilities or biomed asking the right question.	“Agreed — a bare cellular dialer is not. This is a managed MFVN: broadband primary, cellular secondary, 48-hour battery, monitored 24/7, UL 864 10th Edition, listed by the California State Fire Marshal and recognized by FDNY. Your AHJ and your insurer get the certification package up front.”
“Corporate/the MSO decides on vendors.”	Buying authority is upstream — this is the bigger opportunity.	“Perfect. Who owns telecom standards at the platform level? Here is what we will do: run the free audit at this site so corporate sees real numbers from a real clinic — administrators who bring corporate a documented savings-and-compliance

Objection	What It Really Means	Response
		finding get listened to. We standardize across platforms for a living; add-a-site pricing is the point.”
“We just signed with a phone/UCaaS vendor.”	Voice is taken; the wedge is everything voice vendors cannot touch.	“Keep them — this is not that. Your UCaaS vendor cannot put a fire panel, a vaccine fridge alarm, or a compliant fax line on their platform. We take the analog and life-safety estate they left behind, and when their renewal comes up you will have one vendor who can do both.”
“No budget — reimbursements are getting squeezed.”	Real pressure; the answer is that this is a cost reduction.	“This is not new spend — it replaces line items you already pay, usually at 50–70% less. The audit is free and routinely finds orphan lines you can disconnect the same week. In a margin-squeezed practice, this is one of the few compliance projects that funds itself.”
“We tried VoIP and the quality was bad.”	Prior unmanaged deployment.	“Bad VoIP is an unmanaged-network problem — clinics running EHR, imaging, and voice on one flat network need QoS engineering. We deploy managed routers, monitor 24/7, add LTE failover, and give life-safety lines their own cellular path. That is why we survey before we quote.”
“Send me something.”	Polite exit.	“Happy to. To make it useful: how many locations, roughly how many fax machines, and do you know whether your alarm and fire panel lines are still copper? That is all I need to send a savings-and-compliance snapshot for the group instead of a brochure.”

7. Sequenced Outreach

Sequence A targets practice administrators and ASC administrators; Sequence B targets MSO/chain corporate ops and IT. Both are 8 touches over ~21 days. Personalize with specialty, site count, payer mix hints, and building type. Call windows: Tuesday–Thursday, 1–3pm (post-lunch scheduling lull). Never call Monday morning.

7.1 Sequence A — Practice / ASC (Administrator)

Day	Channel	Touch
1	Email 1	Fax + copper trigger (copy below)
3	Call + VM	Reference Email 1; offer the free line-and-fax audit (script below)
5	LinkedIn	Connect with administrator; no pitch
8	Email 2	Cost angle: copper math + orphan lines (copy below)
11	Email 2b (to Compliance Officer, if identified)	Parallel touch: secure fax architecture summary, offer of a security documentation review
14	Email 3	Missed-calls / on-call angle (copy below)
17	Call	Direct ask: 20-minute audit meeting; two time slots
21	Email 4	Breakup with the audit checklist attached (copy below)

Email 1 — Fax + copper trigger (Day 1)

Subject: The fax machines and alarm lines at [Practice] are on borrowed time

[First name] —

AT&T began permanently retiring copper phone infrastructure in June, with legacy service ending across 18 states as of this November. For medical practices, the exposed lines are the ones clinical operations quietly depend on: referral and lab fax, vaccine fridge alarms, the fire panel at your surgery center, and the security dialer.

Two problems ride on the same copper: the lines are going away, and the faxes on them move PHI with no encryption and no audit trail — the exact thing a HIPAA risk assessment flags.

We replace the lines with fire-marshal-listed, monitored equipment and move fax to a secure platform — your machines and staff workflows can stay exactly as they are. Cutover is scheduled around patient hours.

Worth 20 minutes? We will inventory every analog line and fax machine across your locations at no cost. Most groups cannot currently produce that list — and their phone bills prove it.

[Signature]

Email 2 — Cost angle (Day 8)

Subject: What [Practice] pays monthly for lines nobody can name

[First name] —

Groups your size typically carry 3–6 legacy analog lines per site — fax, fridge alarms, security, and a few from two owners ago that still bill every month. Copper now runs $100–$200 per line; across [N] sites that is real money in a reimbursement environment that is not getting friendlier.

Our replacement runs $19.95–$39.95 per line on fixed terms, certified for fire alarm and elevator circuits, with battery and cellular backup copper never had. The audit routinely finds orphan lines you can disconnect immediately.

It is free, takes about 45 minutes per site, and you keep the inventory either way. Would Tuesday or Thursday afternoon work?

[Signature]

Email 3 — Missed calls / on-call angle (Day 14)

Subject: The scheduling call that rang out at 4:50 yesterday

[First name] —

Different angle from my earlier notes. Most practices we audit are missing 10–20% of inbound calls at peak — lunch, end of day, Mondays. Every missed scheduling call is a slot that goes unfilled or a referral that books elsewhere, and your no-show dashboard already tells you what a slot is worth.

Our hosted platform adds scheduling queues, overflow to staff mobiles, after-hours and on-call routing that actually works, and recording for training — plus direct 911 with room-level location, which newer federal rules expect of multi-line systems.

It rides the same project as the line replacement. Happy to estimate your current answer rate from carrier reports before you change anything. 20 minutes?

[Signature]

Email 4 — Breakup (Day 21)

Subject: Closing the file on [Practice] — one thing before I do

[First name] —

I will stop reaching out after this. Attached is the checklist we use to audit analog lines and fax in medical practices — referral/lab fax, fridge alarms, fire panel, security, elevator. Hand it to your office managers; if everything is accounted for, encrypted where it should be, and on copper that is not being retired, you genuinely do not need me.

If anything is uncertain — especially the fax estate and the alarm lines — my number is below. The audit is free whenever you want it.

[Signature]

Cold call / voicemail script (Day 3)

Live: “Hi [name], [rep] with MIX Networks — I will be brief because I know your afternoon is scheduled. We replace the copper lines medical groups have on fax machines, vaccine fridge alarms, and fire panels before the carriers retire them, and we move fax onto a platform that

encrypts and logs — the thing HIPAA risk assessments keep flagging. I am asking for 20 minutes to inventory your lines and fax machines at no cost. Would Tuesday or Thursday around 1:30 work?”

Voicemail (under 25 seconds): “Hi [name], [rep], MIX Networks. The copper lines most practices still run fax, fridge alarms, and fire panels on are being retired by the carriers. We replace them with fire-marshal-listed equipment and compliant fax. Email is in your inbox — [callback number]. Thank you.”

7.2 Sequence B — MSO / Chain Corporate (VP Ops, IT)

Day	Channel	Touch
1	Email 1	Platform framing: standardized per-site telecom package for acquisitions; one MSA, add-a-site pricing, day-one integration playbook for every practice they buy
3	LinkedIn	Connect; engage substantively with platform growth news
5	Call + VM	Reference audit; cite comparable finding (“an 8-site group we audited carried 31 billable analog lines and could map 19 — and 22 unencrypted fax machines”)
9	Email 2	Risk framing: fax estate + EP Rule posture across N certified sites is portfolio compliance exposure; offer a 2-site audit pilot with findings deck at corporate
12	Email 3	Economics: per-site reference pricing at portfolio terms; 60-month rates; orphan-line recovery typically self-funds the transition
16	Call	Direct ask: 30 minutes with ops + IT; propose pilot at their two most recent acquisitions (worst telecom hygiene, fastest proof)
19	Email 4	Pilot proposal in writing: free audits at 2 sites, no obligation
23	Email 5	Breakup + reference offer: a multi-site administrator willing to take a call

Cadence discipline: stop on engagement; log everything. Healthcare administrators change organizations often and remember reps who respected their time — the relationship outlives the account.

8. Discovery Scripts

8.1 First Meeting Script (20–30 minutes, Practice/ASC Administrator)

Open (2 min):

"Thanks for carving out time between clinic blocks. My goal: understand what rides on your analog lines and fax machines, what it costs, and whether we can reduce both the bill and the compliance exposure. If we cannot, I will tell you. Fair?"

Situation — fax and clinical flows (6 min):

1. How many fax machines across all sites, and what moves through them — referrals, prior auths, labs, Rx? Any misdirected-fax incidents or near-misses?
2. Has fax come up in your HIPAA risk assessment or a payer audit? Who owns compliance — internal officer or consultant?
3. Vaccine storage on site? How are fridge/freezer temperatures alarmed after hours? (VFC participants: what does your excursion protocol assume about the alarm line?)

Situation — life-safety and building (5 min):

1. For the ASC/MOB sites: fire alarm panels — monitored over what? Last fire inspection and any findings? Elevators, and when are certs due?
2. Are you CMS-certified (ASC, dialysis, FQHC)? When is the next survey window, and what does your EP communication plan list as the alternate method today?
3. Any letters from AT&T/[ILEC] about copper retirement? Who opens carrier mail?

Situation — phones, money, and structure (7 min):

1. Phone system(s) by site — age, vendor, support status? One system or a patchwork from acquisitions?
2. What happens to a scheduling call at 12:15 or 4:50? Do you know your answer rate? How does after-hours/on-call routing work, and when did it last fail?
3. Can we pull 2–3 months of telecom bills across sites? Total spend? Lines nobody can identify?
4. Ownership structure — independent, MSO-affiliated, PE platform? Who signs a multi-site services agreement, and is vendor consolidation underway?

Quantify and close (5 min):

"Based on what you have described — roughly [N] specialty lines, [M] fax machines, [ASC/certified-site exposure], and a [age] phone system — here is the proposal: a free site survey. We inventory every analog line and fax machine, identify life-safety and alarm circuits, and return a site-by-site replacement plan with firm pricing — a document your compliance file benefits from regardless. Can we schedule the first walk with your office manager next [day]?"

8.2 On-Site Audit Checklist (per site)

- Demarc/MPOE: photograph blocks, count active pairs, trace tags.
- Fax census: every machine, location, what flows through it, volume estimate, whose number is published where.
- Med storage: fridge/freezer alarm dialers, monitoring service, after-hours notification path.

- ASC/MOB: fire panel make/model/monitoring company/line count/last test; elevator lines and cert dates; generator and med-gas monitoring.
- Security: burglar alarm, panic buttons, door entry.
- Business office: billing/records fax, postage, POS/ATM.
- Network closet: internet provider(s), bandwidth, switch/PoE, UPS condition, cellular signal at demarc.
- Bills: reconcile every billed line to a device; flag orphans for immediate disconnect.
- EP plan (certified sites): read the communication plan's alternate-comms section; note the gap.

8.3 Qualification Standard (exit criteria for a real opportunity)

- **Trigger confirmed:** retirement notice, HIPAA risk assessment finding, survey window, acquisition integration, phone system failure, or fridge-alarm scare.
- **Line + fax count validated:** 12+ specialty lines or 8+ active fax machines across the group makes economics decisive.
- **Power mapped:** administrator sponsoring; compliance officer engaged (not surprised later); ownership structure and signer identified.
- **Spend known:** bills in hand or committed for the survey.
- **Next step dated:** first site walk scheduled with the office manager.

9. Proposal Template

Under 10 pages plus the line-and-fax inventory appendix. Write for three readers: the administrator (economics and operations), the compliance officer (security architecture), and the physician owner (one-page summary up front). Every number anchored to the Site Survey Report.

Section 1 — Cover and Executive Summary

Title: Analog Line Replacement, Secure Fax, and Voice Modernization for [Group/Facility Name]

Prepared for: [Name, Title] | Prepared by: [Rep, MIX Networks] | Date: [Date] | Valid: 30 days

Executive summary (5 sentences max): [Group] operates [N] analog lines and [M] fax machines across [S] sites, including [X] life-safety and clinical-alarm circuits on carrier copper scheduled for retirement. This proposal replaces those circuits with MIX Networks' managed, fire-marshal-listed POTS replacement platform, migrates fax to a secure platform supporting HIPAA technical safeguards, and [optionally] modernizes voice with scheduling queues, on-call routing, and suite-level 911. Monthly telecom spend moves from approximately $[current] to $[proposed], a [%] reduction on fixed [term]-month pricing. Every life-safety and alarm circuit gains dual-path transport, up to 48-hour battery, and 24/7 monitoring — with documentation formatted for the group's compliance file and, for certified sites, the EP communication plan. Installation is staged around patient care and OR schedules and documented line by line.

Section 2 — Current State (from Site Survey Report)

- Line inventory appendix by site: line number, location, purpose, carrier, monthly cost, disposition (replace / port / disconnect).
- Fax census by site: machine, workflow, volume, current transport, proposed migration path (ATA-preserve vs. portal).
- Orphan lines for disconnection: [N] lines, $[amount]/mo immediate savings.
- Compliance exposures, stated factually: [unencrypted PHI fax flows; panel on copper without secondary path; EP plan alternate-comms gap; 911 location gaps].
- Carrier retirement status for serving wire centers, if known.

Section 3 — Proposed Solution

- **POTS Replacement:** one 90X2/90X1 per site; circuit-by-circuit FXS mapping; broadband primary, 4G/5G secondary; up to 48-hour battery; 24/7 monitoring with proactive notification on alarm-line state changes.
- **Secure Fax:** deployment per site per the fax census — cloud portal, ATA preserving existing machines, or hybrid; Email-to-Fax/Fax-to-Email; TLS transfer, authenticated access, protected storage, delivery confirmation and audit reporting; security architecture documentation for compliance review; business associate discussion coordinated with MIX contracting.
- **Compliance package:** UL 864 (10th Ed.), UL 62368-1, UL 2054; NFPA 72 Ch. 26.6 MFVN architecture; CSFM Listing 7305-2384:0002; FDNY MFVN recognition (2025-TMFRAL-007143-VRNC); FCC Part 68/15; AHJ documentation per building; NFPA 72 Ch. 14 retest coordinated with [alarm company]; EP-plan exhibit for certified sites.

- **Hosted Voice (if in scope):** [N] seats; auto attendants; scheduling queues with overflow; after-hours/on-call routing; compliant recording [retention noted]; UCFone for providers and on-call; direct 911 with per-suite dispatchable location; [N] Yealink handsets; managed QoS routers with LTE failover per site.

Section 4 — Implementation Plan

1. Install Prep: provisioning, staging, SIM activation, SIP registration before shipment; cutover calendar by site agreed with [administrator], scheduled around clinic hours and OR days.
2. Install / Test-and-Turn-Up: site-by-site installation, DMARC cross-connect, functional test on every line and fax path, photographed and documented.
3. Life-safety and alarm verification: fire panel Test Mode coordination, 60-second voltage-drop sequence, training-call validation, return to Normal Mode, NFPA 72 Ch. 14 retest (ASC/MOB); fridge/security alarm test-signal verification with monitoring companies.
4. Fax migration: number porting per the census; parallel-run window; confirmation of inbound delivery from top referral sources before copper release.
5. Training and handoff: front-office and clinical staff training per site; compliance documentation packet delivered; 24/7 U.S.-based support; quarterly reviews.

Section 5 — Investment

Reproduce Section 5 deal-math tables with surveyed quantities across 36/48/60-month columns, side-by-side against documented current spend. Itemize one-time charges (provisioning $45/device; Fax ATA $100; installation per SOW at $165/hr, 2-hr minimum) separately from MRR. For MSO/platform deals, include the portfolio schedule: per-site pricing, add-a-site terms. Close with:

“Pricing is firm for 30 days and based on the Site Survey Report dated [date]. Line and fax counts verified at installation; additions priced at the same per-unit rate for the term.”

Section 6 — Why MIX Networks

- The only bidder covering both halves of the problem: fire-marshal-listed life-safety line replacement (CSFM + FDNY recognition — ask competitors for theirs) and a secure fax platform built for regulated document flows.
- 20+ years of telecom operating history; geo-redundant carrier-grade core (Dallas, Secaucus, Lakeland, Ashburn, Las Vegas), 99.999% uptime target.
- Managed installation documented line by line, scheduled around patient care; multi-site healthcare and senior care references available on request.
- Security-forward architecture end to end: TLS, secure SIP, MFA on device UI, firewall defaults — built to pass your vendor risk assessment, not negotiate with it.

Section 7 — Acceptance

Signature block, term selection (36/48/60), billing details, and: “Upon acceptance, MIX will schedule Install Prep within [X] business days and assign a named project coordinator experienced with clinical-environment scheduling.”

10. Running the Play: First 90 Days

Weeks	Activity	Target
1–2	Territory build: state ASC license lists and Medicare provider files (public), MGMA chapter rosters, MOB inventories from commercial property data, dialysis/imaging/urgent care chain maps; flag multi-site groups, recent acquisitions, and wire centers with announced retirements	80 targets listed, 20 flagged priority
2–6	Run Sequence A on 20 priority groups/ASCs; Sequence B on 5 MSOs/chains; brief 2–3 healthcare MSPs as channel allies; attend one MGMA chapter or state ASC association event	10 audit meetings booked
4–10	Deliver site walks with office managers; produce Site Survey Reports with the fax census; proposals within 5 business days, compliance-officer security review offered in every one	6 proposals out
8–13	Close and install first groups; harvest immediately: MSO expansion from pilot sites, MOB property-manager referrals into tenant suites, administrator references for the association circuit	2–3 closed groups; 1 MSO pilot

KPIs: audits delivered, fax machines censused per audit (the attach predictor), audit-to-proposal rate (target 60%+), proposal-to-close (target 40%+), lines + fax users per closed group, MSO/platform expansion revenue at 12 months, and MSP-referred opportunities.

Final discipline note: healthcare rewards the rep who respects the compliance officer. Bring the security documentation before they ask, route BAA questions to contracting instead of improvising, say “supports HIPAA technical safeguards when properly configured” instead of “HIPAA compliant,” and schedule around patient care without being asked twice. In this vertical, precision is not just the pitch — it is the vendor risk assessment you have to survive to get paid.