

# rev.health

The ambient-AI-native EMR that gives time back to the exam room — and gets independent practices paid correctly the first time.

**SEED ROUND · \$4M · 2026**

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# Independent primary care is being squeezed from both ends

**2–3 hrs**

of after-hours “pajama-time” charting per clinician, every night

**5–10%**

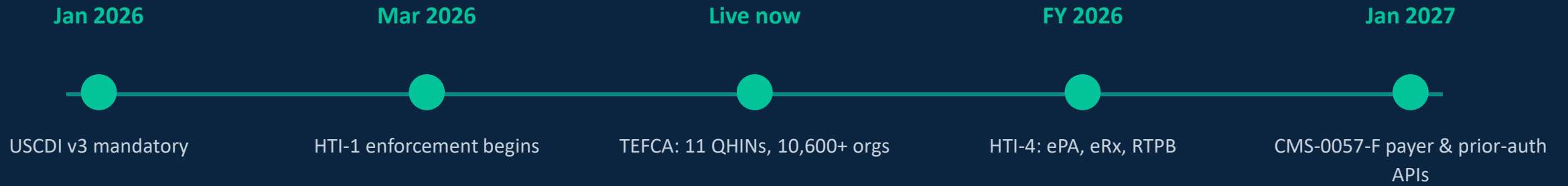
revenue leakage from fragmented billing and untriaged denials

**30–60**

day AR cycles, with billing staff spending 70% of time on rework

**The incumbents have outgrown this buyer.** Cloud RCM suites price and complexify for larger groups; lower-tier EMRs ship weak interoperability and aging UX. 1–5 clinician practices — the largest underserved segment in ambulatory health IT — are left behind.

# A once-per-decade regulatory window is open



**Every incumbent must retrofit. We get to start native.** Independent practices cannot fund FHIR, payer-API, and certification uplifts alone — a vertically integrated platform that is FHIR-native, AI-native, and TEFCA-connected from day one wins the segment.

# One platform: EHR + practice management + RCM

## AI-native — a first-class citizen

Built around two promises:

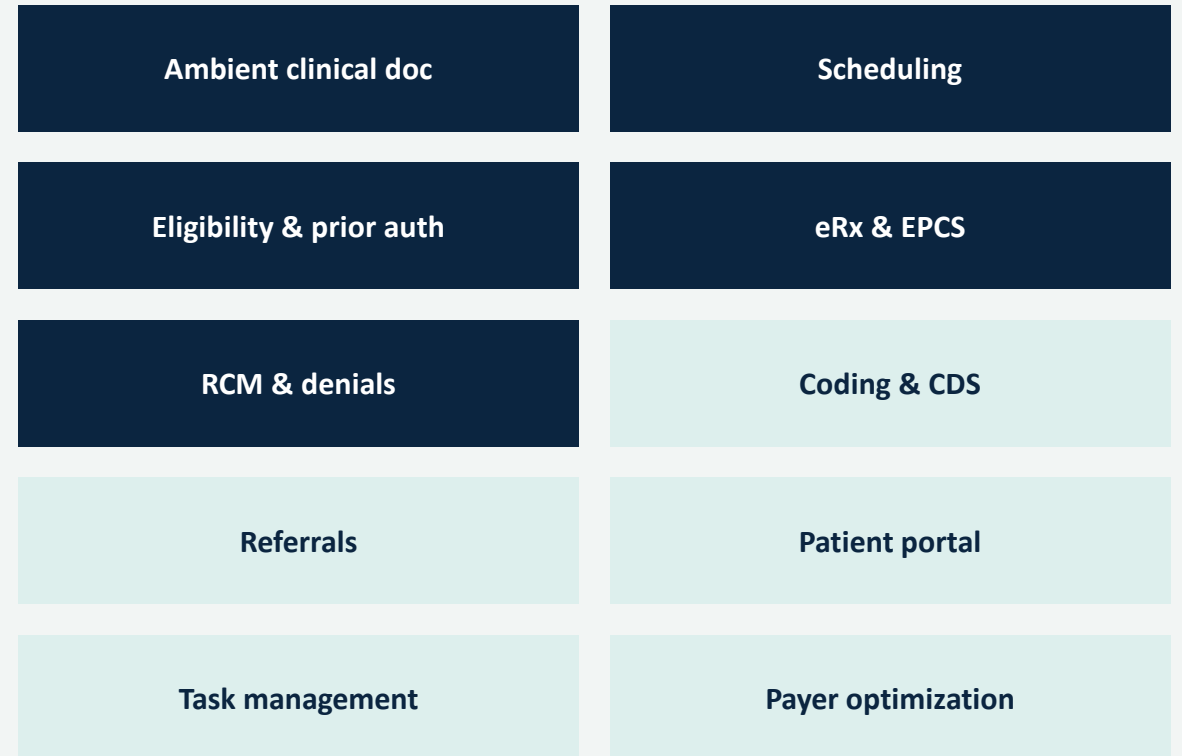
### The note is done before the clinician leaves the room

Structure-first ambient scribe fills coded fields — problems, meds, orders — with every line traceable to the audio.

### The practice is paid correctly the first time

Native charge capture → 10K+ rule scrubbing → auto-posting → AI denial triage. Target ≥98% first-pass clean claims.

### 10 MODULES, ONE DATA MODEL



*Dark = wedge modules in seed-funded MVP scope*

# Four things no incumbent ships today

We looked hard at the top 30+ EMR/RCM options while opening our own practices.



## Structure-first ambient scribe

Not a transcript generator. Output writes back into the problem list, A/P, and orders as bounded coded fields, each linked to audio evidence.



## Resource-graph scheduling

Minute-level constraint solver across clinicians, rooms, staff, equipment. No off-the-shelf small-practice option exists — this is a build. Our data: per-minute scheduling lifts utilization ~20%.



## Turn-key integrated RCM

Athena's model still requires the practice to hire its own billing coordinator. Ours doesn't: capture → scrub → submit → post → appeal, natively.



## FHIR-native, TEFCA day one

USCDI v3 baseline, CMS-0057-F prior-auth APIs, QHIN connection at launch — compliance as a feature, not a retrofit.

# Patients are users. Clinical data is global.

Every other EMR locks the chart inside the practice. We invert the model: the patient owns one portable record; practices connect to it.



## One identity

Patient = user. Switch practices, the chart travels intact. No re-entry, no faxes.



## Every read audited

Patients see who viewed their record and why — a first-class feature, not a buried report.



## Compounding data

Each new practice deepens the longitudinal record — over time, more complete than Epic's view for our patients.

*Network effect: every practice added makes the product more valuable to every patient — and harder to leave.*

# We demoed them all — here’s what the buyer actually faces

Vendor	Price signal	What the demos exposed (2026, recorded)
<b>athenahealth</b>	4–7% of collections + \$1,000+/prov/mo all-in	RCM not turn-key — practice must still hire its own billing coordinator. Lukewarm on small practices.
<b>eClinicalWorks</b>	\$449–599/prov/mo + 2.9% RCM	\$155M DOJ False Claims settlement; AI features failed live in our demo; export = support case.
<b>NextGen</b>	Quote-based + \$125/prov/mo AI add-on	2023 breach: 1.05M people, \$19.4M settlement. Rep couldn’t produce breach indemnity language.
<b>Elation</b>	~\$300–450/prov/mo (opaque)	Closest in spirit, but no integrated RCM, no resource-graph scheduling, no structured scribe write-back.

**rev.health: \$595/prov/mo + 4.9% of collections — integrated, transparent, and built for the 1–5 clinician practice.**

ML-based, not rules-based — every encounter teaches the system, so we expect ≥15% more efficient than anything we evaluated. Newly affordable: too costly to attempt just a few years ago.

Competitors’ all-in run past \$1,000/provider/mo once AI + hidden fees are added — full breakdown in the investor portal (EMR comparison).

## The largest underserved segment in ambulatory health IT

**\$15B+**

US ambulatory EHR / PM / RCM software & services (TAM)

**~\$4B**

Independent primary care, 1–5 clinicians —  
bottom-up: ~60K practices × ~\$65K ACV  
(SAM)

**\$55.6M**

Exit ARR at 460 practices by 2031 — ~1.4%  
of segment (SOM)

**Expansion path:** the same platform serves high-collections specialties (ortho, cardio, GI), where the RCM fee yields a multiple of the per-provider revenue — a pure ACV lever after the primary-care beachhead.

*Sizing is bottom-up illustrative; sources and math in the data room.*

# Two revenue engines per provider

## SaaS subscription

**\$595** /provider/mo

EHR, scheduling, eRx/EPCS, portal, scribe included

## Integrated RCM

**4.9%** of collections (90% attach)  
vs. other health 4–7% — and ours includes denial work

**~\$48K**

revenue per provider / yr

**~\$121K**

ACV per practice (2.5 providers)

**79%**

blended gross margin

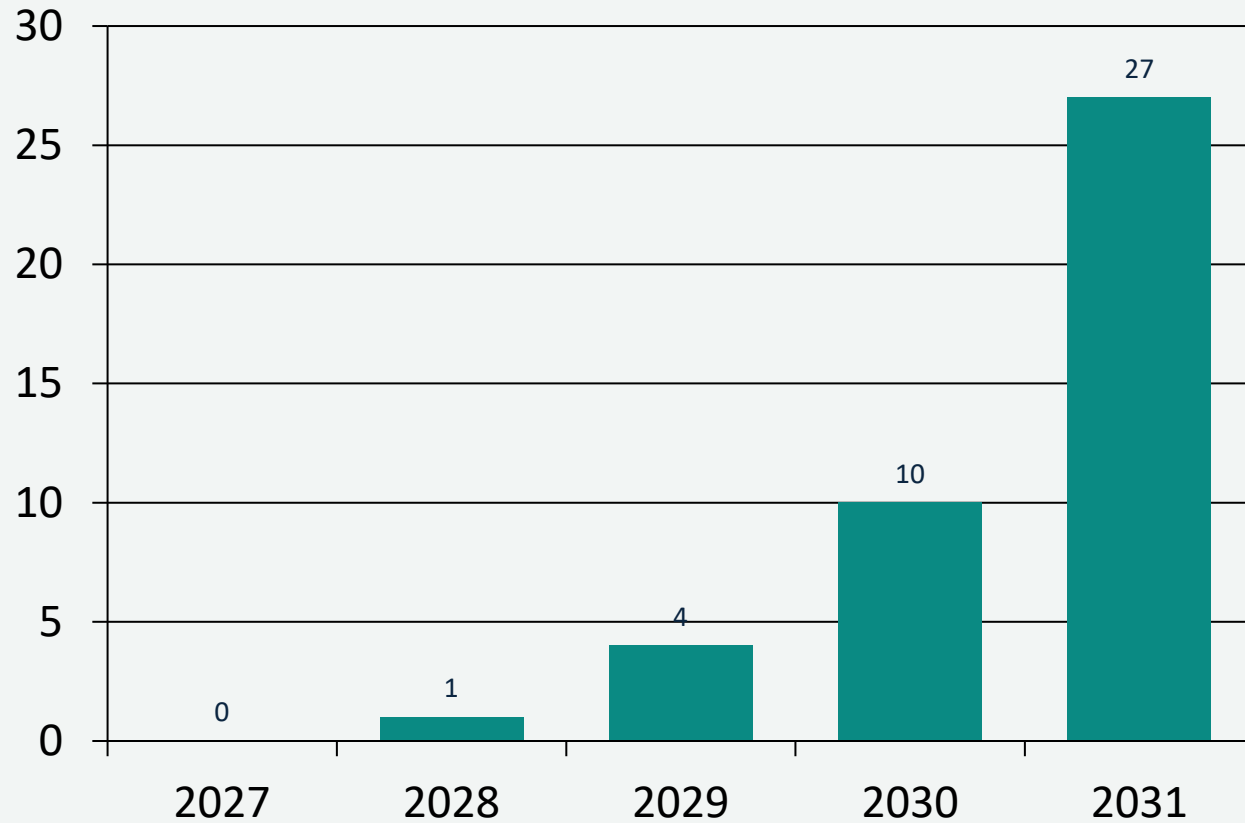
**Short cycles**

one-clinician buying decision

*Year-1 design partners at 50% discount; full pricing at GA (2028).*

Pricing is conservative — room to raise rate and collection % as the platform hardens, and new specialties command higher pricing. Largely incremental margin.

# Path to \$26.9M revenue by 2031



Full 5-year model with assumptions in the data room.

<b>460</b>	practices by 2031 (from 5 design partners in 2027)
<b>\$55.6M</b>	exit ARR run-rate, 2031
<b>2028</b>	GA launch after ONC certification; \$12M Series A assumed H2
<b>+\$16.9M</b>	EBITDA in 2031; 78% gross margin throughout

# Certification is the critical path — and it starts now

**H2 2026 — P0**

## **Foundation**

Core team hired, architecture stood up, Drummond ONC + Surescripts EPCS engagements kicked off (9–12 mo each).

**2027 — P1**

## **Alpha with design partners**

Scheduler, ambient scribe, eligibility, charge capture, eRx live in 3–5 friendly clinics. Paying design partners.

**2028 — P3 GA**

## **Certified launch**

ONC cert complete, full RCM with denials & appeals, MIPS, TEFCA, SOC 2 Type II. General availability.

**2029+ — P4**

## **Expansion**

Specialty verticals, telehealth, HITRUST i1, Bulk FHIR, predictive scheduling. Scale to 2500+ practices.

*Seed funds carry the company through GA-readiness; Series A (assumed H2 2028) funds the go-to-market scale-up.*

# De-risked before a single line of production code

- ✓ 10-module PRD: exec, developer, and data-model views — 44 documents, validated
- ✓ Full regulatory matrix: 15 frameworks mapped to product posture and timeline
- ✓ Competitive teardown incl. recorded 2026 vendor demos (athenahealth, NextGen)
- ✓ Working UI prototypes: dashboard, scheduling day-view, live status board + 6 more
- ✓ Architecture decided: FHIR-native, schema-first codegen, patients-as-users model

## NEXT 90 DAYS

- ✓ Close seed round
- ✓ Sign 3–5 design-partner LOIs
- ✓ First 4 engineering hires
- ✓ Drummond + Surescripts kickoff

# Built by people who've lived the problem



**Patrick Feeney**

Co-founder & CEO

*Investor, founder, and advisor based in Dallas.  
Leads strategy, fundraising, and go-to-market.*



**Jeff Hughes**

Co-founder & CTO

*Technical founder and architect of the rev.health  
platform — from the data model to the ambient-AI  
workflows.*



**Daniel Dow, M.D.**

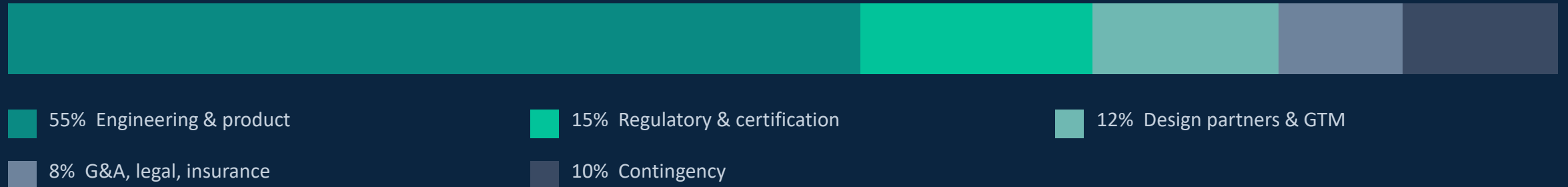
Co-founder & Subject-Matter Expert

*Physician, venture partner, and founder  
championing autonomy and ownership in medicine.  
Columbia Business School.*

*Advisory board in formation: RCM operator, health-IT regulatory counsel, 2 practicing PCPs.*

## THE ASK

# \$4M seed to reach certified general availability



## WHAT IT BUYS BY SERIES A (H2 2028)

- ✓ ONC §170.315 + EPCS certification complete
- ✓ Wedge product live: scribe, scheduling, RCM core
- ✓ 3–5 design partners live and paying
- ✓ ~\$55.6M exit ARR run-rate at 2031 exit

## INVESTOR RETURN · 10× EXIT (2031)

**\$4M → \$111M · 27.8× MOIC · \$107M gain**