



Palladian Muscular Skeletal Health


Wellflex
Health and Wellness

Network Participation Application

Complete the Palladian Health Network Participation Application form. Palladian Health (hereinafter referred to as "Palladian"). Your Signature on this application is your acknowledgment and acceptance of the following participation criteria for contracting as a Palladian Practitioner.

I submit that all the information contained herein to be accurate and correct to the best of my knowledge. I further understand that willful omission or misrepresentation of any information will be just cause for immediate denial of this application, or termination as a Palladian practitioner. All information submitted by me in this application is warranted to be true and correct.

I understand and agree that I, as an applicant to Palladian Health, have the burden of producing adequate information for the proper evaluation of my credentials, including professional competence, character, ethics and other qualifications and I am responsible for providing adequate information and documentation to resolve any doubts about such qualifications. I further agree to notify Palladian Health, LLC, (within 30 days) if any information provided on this application changes.

By applying for participation with Palladian, I hereby agree to:

- Authorize Palladian or it's representatives, to consult with past and present insurance carriers who may have information regarding my credentials;
- Consent to inspection by, and release to, Palladian Health all records and documents that may be material to an evaluation of any professional competence as well as my licensure status, education, training, experience, and ethics;
- Release from liability all representatives, employees or agents of Palladian for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications; and
- To be bound to the terms of Palladian policies and procedures in all matters relating to the consideration of this application, and to agree that, if an adverse ruling is made with respect to your application, you will be required to follow intra-organizational policies and procedures before resorting to any formal legal action challenging the decision, procedures used to arrive at, or asserting any claim against Palladian or participants in the decision process.

Submission of this application does not automatically result in acceptance of your application by Palladian.

Print Name: _____

Signature: _____

Date: _____



Palladian Muscular Skeletal Health


 Wellflex
 Health and Wellness
Network Participation Application

Please complete the following pages that are applicable to your organization. Please note, a separate application must be completed for each location.

Facility Name: _____

Contact Name: _____

Facility Address: _____ **City:** _____

State: _____ **Zip:** _____ **County:** _____

Facility Phone #: _____ **Facility Fax #:** _____

Website Address: _____ **Tax ID Number:** _____

Email Address: _____ **Number of Years in Business:** _____

Fitness Facilities ONLY: Have you filed a bond with the Secretary of State or with a financial institution? No Yes / Please List: _____

Type of Club: Co-Ed Women Only Men Only

Services Offered		
<input type="checkbox"/> Fitness Facility Memberships	<input type="checkbox"/> Cooking Classes	<input type="checkbox"/> Martial Arts & Self-Defense
<input type="checkbox"/> Personal Training	<input type="checkbox"/> Yoga*	<input type="checkbox"/> Health Store
<input type="checkbox"/> Spa Services	<input type="checkbox"/> Reflexology*	<input type="checkbox"/> Children's Day Camp
<input type="checkbox"/> Dance Studio	<input type="checkbox"/> Acupuncture Services**	<input type="checkbox"/> Red Cross Certification
<input type="checkbox"/> Children's Swimming & Gymnastics	<input type="checkbox"/> Chiropractic Maintenance Services**	<input type="checkbox"/> Pilates*
<input type="checkbox"/> Children's Fitness Programming	<input type="checkbox"/> Massage Therapy Services**	<input type="checkbox"/> Reiki*

*Current License/Certification must be included with application.
 **A separate application must be filled out by the service provider for consideration into the network.

Additional Amenities	
<input type="checkbox"/> Group Fitness Classes	<input type="checkbox"/> Pilates Studio
<input type="checkbox"/> Child Care	<input type="checkbox"/> Racquetball Court
<input type="checkbox"/> Locker Rooms	<input type="checkbox"/> Sauna
<input type="checkbox"/> Pool	<input type="checkbox"/> Whirlpool

Attestation Page: If the answer to any of the questions is “no”, please explain on a separate sheet of paper and attach the paper.

- Yes** **No** Is your facility handicapped accessible?
- Yes** **No** Are your bathrooms handicapped accessible
- Yes** **No** Does you facility comply with all local, state and federal laws?
- Yes** **No** Are you licensed to do business in your state and do you meet the regulatory standards for all aspects of services offered?
- Yes** **No** Do you attest to having a minimum \$1,000,000 in general liability coverage?
- Yes** **No** Does you facility comply with OSHA Safety standards?
- Yes** **No** Do you inspect and test all safety systems and maintain documentation?
- Yes** **No** Do you agree to maintain a verification of current CPR training of relevant staff?
- Yes** **No** Is your facility made available to persons of all races, creeds or nationalities?
- Yes** **No** Do you agree to directly monitor programs and services offered to members?

I attest that all information contained herein is accurate and correct.

Signature:

Date:

Your Facility's Hours Of Operation

Monday: from _____ am to _____ pm

Tuesday: from _____ am to _____ pm

Wednesday: from _____ am to _____ pm

Thursday: from _____ am to _____ pm

Friday: from _____ am to _____ pm

Saturday: from _____ am to _____ pm

Sunday: from _____ am to _____ pm



Palladian Muscular Skeletal Health



Wellflex

Health and Wellness

Network Participation Application

To expedite the approval process, the required documents listed below must be submitted with your application.

- A completed and signed Palladian Health Network Participation Application.
- A copy of your General Liability Insurance, indicating effective dates and limits of liability, which must be a minimum coverage of one-million.
- Completed and signed two Provider Agreements.
- Completed and signed W-9.
- If applicable, a completed Electronic Funds Transfer form. Please attach a voided check from the authorized financial institution.
- Brochure of services including price list

Please submit completed network applications to:

**Palladian Health
ATTN: Network Management Department
2732 Transit Rd
West Seneca, NY 14224
Fax- 716-712-2791
Phone- 888-266-9041 ext 2903**



HEALTH & WELLNESS PROGRAM AGREEMENT

THIS AGREEMENT is entered into between Palladian Health, LLC (hereinafter referred to as “Palladian”), a Delaware Limited Liability Company located at 2732 Transit Road, West Seneca, NY 14224, and the **Participating Fitness Center** whose name and other identifying information appear on the signature page hereinafter as “Provider”.

I. HEALTH AND WELLNESS SERVICES

Provider will provide those Health and Wellness Services for the Programs specified by Palladian from time to time in accordance with the Program Guidelines.

II. COMPENSATION AND HOLD HARMLESS

1. Provider agrees to accept payment as outlined in the Program Guidelines. Provider understands that the payments it receives from Palladian pursuant to the Program Guidelines constitute payment in full for services rendered by Provider.

2. Provider shall submit all claims to Palladian, and bring any disputes regarding payment by Palladian to Palladian’s attention, within ninety (90) days of receiving payment or remittance report or such other time period as set forth in the Program Guidelines. Failure to timely remit claims and/or disputes to Palladian will result in refusal by Palladian to review any such dispute. Provider agrees to abide by Palladian’s methodologies for receiving payment. If Provider’s fails to adhere to the claims payment process described in the Program Guidelines the Provider will not receive reimbursement and agrees not to charge Participants for the resulting unpaid charges.

3. **Provider Hold Harmless.** No Participant shall be liable to Provider for any services for which the Payor or Palladian is liable. Provider shall not bill, charge, seek compensation, remuneration, or reimbursement from, have any recourse against, or report to a credit agency, the Participant, dependent of Participant, or any persons acting on their behalf, for services provided in accordance with this Agreement. This provision shall not prohibit collection of deductible amounts, co-payments amounts, and amounts for non-covered services. This covenant shall survive the termination of this Agreement, regardless of the cause thereof.

III. INSURANCE AND INDEMNIFICATION

1. Provider will acquire and maintain, at its sole expense such policies of comprehensive general liability insurance in amounts consistent with Palladian’s credentialing standards and the Program Guidelines. Provider and Palladian agree to adhere to and be bound by the common law and statutory principles of indemnification and contribution as they exist in the jurisdiction in which Provider renders services.

IV. TERM AND TERMINATION

1. This Agreement with Palladian is effective on the date that it is signed by both Parties hereto and shall remain in effect until terminated. Either party may terminate this Agreement at any time upon at least sixty (60) days prior written notice to the other Party. Palladian may also terminate this Agreement immediately upon written notice to Provider in the event Provider commits fraud or as necessary to protect the health and safety of Program Participants.

2. Termination shall not relieve Provider of obligations with respect to services furnished prior to the termination date, or for obligations listed above under section “Protections for Participant Subscribers”.

V. CONFIDENTIALITY

Provider agrees to hold in confidence and not to disclose to any other third party any of the terms and conditions of the Agreement, Amendments thereto, the Program Guidelines or other proprietary Palladian information. Provider agrees to comply with federal, state and local laws, rules, regulations and ordinances protecting the confidentiality of health care records. In the event that Provider violates this paragraph, Palladian shall have the right to immediately terminate the Agreement upon written notice to the Provider. This paragraph shall survive the termination of the Agreement regardless of the cause thereof.

VI. MISCELLANEOUS

1. The Program Guidelines are hereby incorporated into this Agreement by reference. Palladian may modify this Agreement and/or the Program Requirements upon written notice to Provider. In the event of any conflict between this Agreement and the Program Guidelines, the Program Guidelines shall control. In addition, Provider agrees to comply with those additional requirements that are set forth in Schedule A, Compliance Provisions, attached hereto and incorporated herein. In the event of any conflict between Schedule A and terms of this Agreement or the Program Guidelines, Schedule A shall control.

2. This Participating Provider Agreement may not be assigned or transferred without the written consent of Palladian, which consent shall not be unreasonably withheld; provided, however, that Palladian shall have the right, in its sole discretion, upon notification to Provider, to assign any or all of its rights, duties and obligations hereunder to any corporation related to Palladian.

VII. DEFINITIONS

For purposes of this Agreement in addition to the terms elsewhere defined herein, the following terms shall have the meanings indicated:

1. **Health and Wellness Services** means all health-related services and products which may be lawfully provided or dispensed by one who is duly licensed and/or credentialed to practice in the field under the laws of the state in which they practice, and which are covered under Participant’s benefit plan.

2. **Payor** is an entity such as a health plan, third party administrator, network, employer group or benefit plan, governmental entity, association or other entity that has entered into an agreement with Palladian pursuant to which Palladian is responsible for arranging Health and Wellness Services to Participants.

3. **Participant** is an individual who is entitled to health care benefits by virtue of a benefit plan or program adopted by a Payor.

4. **Program Guidelines**. A Program Guideline is a document provided by Palladian to Provider setting forth the administrative and operational procedures of the applicable program (“Program”) in which the provider participates. This will include the description of the Health and Wellness Services, claims payment, fee schedule amounts, and other processes as it relates to administration of each benefit.

IN WITNESS WHEREOF, the Parties have each executed the Agreement in the space provided below as of the Effective Date set forth herein.

PALLADIAN HEALTH, LLC

PROVIDER

By: _____

By: _____

Paul J. Candino, President

Name/Title: _____

Date: _____

Date: _____

PROVIDER NAME: _____

PROVIDER TAX ID#: _____

PROVIDER ADDRESS: _____

**SCHEDULE A
MEDICARE ADVANTAGE PROGRAM
COMPLIANCE SCHEDULE**

As part of Provider's obligations under this Agreement, Provider agrees to abide by all applicable provisions of the Medicare Contract and to fulfill Provider's obligations hereunder in a manner consistent with Plan's obligations under the Medicare Contract. Provider's compliance specifically includes the following:

1. Audits/Access. Provider shall permit audits and inspection by the United States Department of Health and Human Services, the Comptroller General of the United States, CMS and/or their designees regarding any pertinent contracts, books, documents, papers and records (collectively, "Books and Records") involving or relating to Provider's provision of services to Participants. All such Books and Records shall be made available by Provider for a period of ten (10) years from the termination of the applicable Medicare Contract or ten (10) years from the date of completion of any audit or in certain instances described in applicable Medicare regulations, for periods in excess of ten (10) years, if appropriate.

2. Patient Confidentiality; Accuracy of Records. Provider shall be bound by any patient confidentiality provisions set forth in Payor's policies and procedures, as well as federal and state laws and regulations and the provisions of the Medicare Contract regarding confidentiality and disclosure of medical records or other health or enrollment information pertaining to Participants. Without limiting the generality of the foregoing, Provider agrees to: (i) safeguard the privacy of all Participant medical records and ensure that copies of or information from such records are released only to authorized individuals; (ii) release such records only in accordance with applicable federal or state laws or pursuant to court orders or subpoenas; (iii) maintain all such records in an accurate and timely manner; and (iv) ensure timely access by Participants to records and information that pertain to them.

3. Participant Hold Harmless. Provider acknowledges and agrees that in no event, including but not limited to the insolvency of Palladian or Payor, breach of the Agreement and/or non-payment for services by Palladian or Payor, shall Provider bill or seek compensation from or assert any legal action against Participants or persons acting on behalf of Participants for payment of any fees that are the legal obligation of Palladian or Payor.

4. Delegation. Any delegation of functions hereunder shall be in accordance with applicable delegation requirements set forth in the Medicare regulations.

5. Reporting Requirements; Policies and Procedures. Provider acknowledges that Payor is subject to reporting requirements specified in the Medicare regulations. In furtherance of any such applicable reporting requirements, Provider shall comply with all data and reporting requirements of Palladian and Payor. Provider shall also comply with all other policies and procedures of Palladian and Payor.

6. Accountability. Provider acknowledges that Payor oversees and is accountable to CMS for any functions and responsibilities set forth in the regulations governing the Medicare Program. Provider further acknowledges and agrees that pursuant to the Medicare regulations, Payor, Palladian or its/their designees will monitor Provider's performance hereunder and that Payor, Palladian and/or CMS shall have the right to terminate the Agreement and Provider's participation in the Medicare Contract if Provider does not perform satisfactorily hereunder.

7. Compliance. Provider shall comply with and shall require any of its permitted subcontractors that provide services to Medicare Participants to comply with all applicable Medicare laws and regulations and applicable CMS instructions, and with Payor's and Palladian's policies and procedures.

8. Continued Care. Provider agrees that: (i) covered services provided to Participants hereunder shall continue for all Participants for the duration of the Medicare Contract period for which CMS payments have been made to Payor; and (ii) in the event of Payor insolvency or termination of the Medicare Contract for any reason, covered services shall continue until the date of discharge for any Participant confined in an inpatient facility on the effective date of insolvency or termination.

9. Interpretation. In the event of any inconsistency between this Schedule and the Agreement, the terms of this Schedule shall control.

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,