



NOTE: EACH FACILITY LOCATION
MUST COMPLETE A SEPARATE FORM

Broadlane Physician Services Participation Form

Group / Network Affiliation (optional): _____

Practice / Participant Name: _____

Physician's Name (if different from above): _____

Street Address: _____ Suite: _____

City, State, ZIP: _____

Contact Name: _____ Telephone: _____ Fax: _____

E-mail Address: _____ DEA Number: _____

Practice Type (circle one): Individual Physician Clinic/Group Ambulatory Care Center Urgent Care Center

Total Number of Physicians in Practice: _____

Number of Physicians in each Practice Specialty:

- | | | | |
|--------------------------|---------------------------|----------------------|---------------------------|
| _____ Anesthesiology | _____ General Practice | _____ Ophthalmology | _____ Psychiatry |
| _____ Cardiology | _____ Hematology/Oncology | _____ Orthopedics | _____ Pulmonary Diseases |
| _____ Dermatology | _____ Internal Medicine | _____ Otolaryngology | _____ Radiology / Imaging |
| _____ Emergency Medicine | _____ Nephrology | _____ Pathology | _____ Surgery-General |
| _____ Family Practice | _____ Neurology | _____ Pediatrics | _____ Urology |
| _____ Gastroenterology | _____ OB/GYN | _____ Other | |

Signature of this form confirms that this facility or practitioner agrees to participate in the Broadlane Physician Services program and authorizes Broadlane to act as its purchasing agent. This agreement is subject to the attached Terms and Conditions. Upon execution by Broadlane and Customer this Broadlane Physician Services Participation Form is effective as of the earliest date written below.

The individuals signing below represent and warrant that they are duly authorized and have the full power and authority to execute this Agreement on behalf of all the individuals or entities for whom they are signing and that this Agreement is binding on the individuals or entities on whose behalf they have signed.

BROADLANE, INC.

_____ **[CUSTOMER]**

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

FOR INTERNAL USE ONLY			
Date _____	Time _____	Verification: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Affiliation: _____	# of MD _____	Method: Call <input type="checkbox"/> Web <input type="checkbox"/>	Name _____



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Practice Name: _____

Please designate a distributor that has been authorized to serve Broadlane Physician Services customers. Most distributors use a local account representative – often the same one currently servicing your practice. Selecting a Broadlane authorized distributor most likely will result in a substantial reduction in price.

Medical and Surgical Supplies – *Caligor, GIV, Henry Schein, McKesson, Physician Sales & Service, Inc. (PSS)*

Please check the distributor you prefer. (If you currently are purchasing from any of the distributors listed below, please include your account number and sales representative’s name.)

- I prefer: **McKesson**
 Your acct # _____ Your Rep’s Name _____
- Caligor**
 Your acct # _____ Your Rep’s Name _____
- GIV, a Henry Schein Company**
 Your acct # _____ Your Rep’s Name _____
- Henry Schein**
 Your acct # _____ Your Rep’s Name _____
- PSS**
 Your acct # _____ Your Rep’s Name _____

Standard Hypodermic Needles and Syringes – Becton, Dickinson and Company (“BD”) _____ (initial)

In order to receive Broadlane’s contracted pricing for BD standard hypodermic needles and syringes, you must agree to use BD standard hypodermic needles and syringes for 95 percent of your needs and certify that the above-referenced Practice is one of the following:

- A physician, or a physician practice with admitting privileges at a Broadlane Acute Care Facility;
OR
- A medical clinic, treatment center or urgent care center that is affiliated with a Broadlane Hospital, Surgery Center, Skilled Nursing Facility, Specialty Hospital or Nursing Home

By initialing above, you are stating that you understand that if the above-referenced Participant or Practice does not, or at any time ceases to have (a) admitting privileges in the case of a physician or a physician practice or (b) a valid affiliation with a Broadlane Hospital in the case of a medical clinic, treatment center or urgent care center, the Practice or Participant shall lose access to Broadlane’s contracted pricing on BD standard hypodermic needles and syringes. This is BD’s sole remedy except to the extent the facility committed fraud in its representations of affiliation. **Please initial the line above where indicated if you agree to these terms.**

Broadlane Acute Care Facility Admitting Privileges at: _____
(Facility Name, City, State & Zip)

or

Broadlane Acute Care Affiliation with: _____
(Facility Name, City, State & Zip)

Terms and Conditions

As purchasing agent for this facility or practitioner, Broadlane is acting as a negotiator and will neither take title to, nor be obligated to pay for, any products and/or services whatsoever by virtue of this agreement, any order placed by this facility or practitioner, or any goods and/or services received by this facility or practitioner.

This facility or practitioner acknowledges that each product or service purchased under the Broadlane Physician Services program is subject to the terms and conditions of the applicable manufacturer. Further, this facility or practitioner acknowledges that the products and services made available under the Broadlane Physician Services program are not for resale.

This facility or practitioner understands that vendors from which the goods or services are purchased pay a fee to Broadlane of 3 percent or less of the purchase price of the goods or services sold to this facility or practitioner.

All pricing offered in the Broadlane Physician Services program is considered confidential. Any release of this pricing may cause disqualification from the Broadlane Physician Services program.

This facility or practitioner shall disclose the amount of all discounts (including, but not limited to, price reductions, rebates, and receipt of free items) as required by applicable Medicare law and regulations.

BROADLANE DOES NOT MAKE ANY WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED, AS TO GOODS AND SERVICES PURCHASED UNDER THE BROADLANE PHYSICIAN SERVICES PROGRAM.

This facility or practitioner may change their name, address, and distributor by notifying Broadlane in writing of the change, which notification shall constitute an amendment to this agreement. Notices must be addressed to Broadlane via the mail or e-mail addresses, or fax number as set forth at the bottom of this agreement.

Either party may cancel participation in the Broadlane Physician Services program at any time, without obligation, by contacting the other party at the applicable address set forth on page one of this agreement.

Any of the obligations under this agreement that by their nature are required to be performed following termination of the agreement shall survive the termination of this agreement.

This agreement constitutes the parties' entire agreement on this subject.