



**CREDENTIALING DOCUMENT REQUIREMENTS
FOR NETWORK PARTICIPATION**

IN THE STATE OF MISSISSIPPI

Complete all information and provide documents listed below.* No authorization of services for a Davis Vision plan member shall be granted prior to an applicant's satisfactory completion of the credentialing process.

A VALID NATIONAL PROVIDER IDENTIFIER NUMBER IS A REQUIRED ELEMENT OF THE APPLICATION PROCESS. Provide your Individual NPI number on the application. Provide your Organizational NPI number either on the application or include documentation of your Organizational NPI number from CMS on a separate sheet.

_____ **APPLICATION**

Mississippi Participating Physician Application

_____ **PARTICIPATING PROVIDER AGREEMENT[^]**

[^]All applicants/practitioners must sign and complete all information required on the signature page of the Participating Provider Agreement, and must return the signed (complete), original Provider Agreement to Davis Vision along with a completed and signed credentialing application.

_____ **W-9 FORM**

_____ **COPY OF CSR CERTIFICATE, IF APPLICABLE**

_____ **COPY OF CURRENT CERTIFICATE OF INSURANCE**
(The insurance certificate must indicate coverage in the name of the applicant/practitioner, in a minimum amount of \$1 million per occurrence and \$3 million in the annual aggregate; and current dates of coverage.)

_____ **COPY OF BLANK PATIENT EXAM FORM**

***Kindly forward all documentation to: Davis Vision, Inc., 159 Express Street, Plainview, NY 11803-Attn: Recruiting Dept.**

Instructions For Completing The Mississippi Participating Physician Application

To effectively use the Application, the following is suggested:

- Type or legibly complete the Application in black ink.
- Complete all of the Application **except for line 1, "This application is submitted to:,"**. **Do not sign and date the original.** Keep the completed original on file and keep a blank original for future up-dates. Sign and date as directed below.
- When submitting the Mississippi Participating Physician Application to a credentialing entity:
 1. copy the original Application and any addenda the credentialing entity has requested;
 2. fill in the name of the IPA, medical group, health plan, hospital, etc., to which the Application is being submitted on the top of page 1;
 3. sign and date the copy in the spaces provided;
 4. mail the signed and dated copy to the requesting organization.

By doing the above, your signature will be an original and the date will be current. Remember that the information on the Application must be complete and accurate. An incomplete Application may delay processing.

- Submit completed Applications and do not rely on attached information unless requested.
- If an item in the Application does not apply to you, write N/A in the box provided.
- Attach copies of the documents requested on page 1 of the Application **each time** the Application is submitted.
- For your convenience and to ensure information accuracy, keep Application current at all times.

If you have any questions, please call the Managed Care Entity to which you are submitting this Application.

Please check one:

Mississippi Participating Physician Application

- Original Application
- Reappointment

This application is submitted to: _____, herein, this Managed Care Entity ¹.

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- Face Sheet of Professional Liability Policy or Certification
- DEA Certificate
- Curriculum Vitae
- Board Certification (if applicable)
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birthday Date:	Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).
Social Security #:	Gender ² : <input type="checkbox"/> Male <input type="checkbox"/> Female	
Specialty:	Race/Ethnicity ² (voluntary):	
Subspecialties: Internal Medicine		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City: State: County: Zip:	City: State: County: Zip:
Telephone Number:	FAX Number:
Office Manager/Administrator:	Telephone Number:
	Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

¹ As used in the information Release/Acknowledgements Section of this application, the term “this Managed Care Entity” shall refer to the entity to which the application is submitted as identified above.

² This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	FAX Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ()	
	FAX Number: ()	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: <input type="checkbox"/> Yes <input type="checkbox"/> No	24 Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Back office Telephone Number: ()	
Please identify other networks in which you participate:		
Please identify other networks from which you have been denied admission or de-selected:		
Name of Network	Address	Reason for Denial or Deselection
Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotripsy, mobile testing, MRI, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list:		
Medical Group(s) / IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check all that apply: <input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty <input type="checkbox"/> Group Practice <input type="checkbox"/> Multi Specialty
If Yes, please list specialty(s):		
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list:		
Name:	Type of Provider:	License Number:
Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:	Mississippi Medical License Number:	

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages? Yes NO If Yes, specify limitations:

Do you participate in EDI (electronic data interchange)? Yes No If so, which Network? Do you use a practice management system/software? Yes No If so, which one?

What type of anesthesia do you provide in your group/office?
 Local Regional Conscious Sedation General None Other (please specify): _____

Has your office received any of the following accreditation's, certifications, or licensures?
 American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) Medicare Certification
 Mississippi Department of Health Licensure Other:

IV. BILLING INFORMATION

Billing Company:

Street Address: City:

State: ZIP:

Contact: Telephone Number:

Name Affiliated with Tax ID Number: Federal Tax ID Number:

V. OFFICE HOURS – Please indicate the hours your office is open:

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holidays 24 HOUR COVERAGE

VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company: Telephone Number: Fax Number:
() ()

Mailing Address: City:

State: ZIP:

Covering Physician's Name: Telephone Number:
()

Covering Physician's Name: Telephone Number:
()

Covering Physician's Name: Telephone Number:
()

Covering Physician's Name: Telephone Number:
()

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:

Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:

Billing Name:

Type of Service Provided:

Do you have a CLIA Certificate?

 Yes No

Do you have a CLIA waiver?

 Yes No

Certificate Number:

Certificate Expiration Date:

IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

Medical School:

Degree Received:

Date of Graduation (mm/yy)

Mailing Address:

City:

State & Country:

ZIP:

Medical/Professional School:

Degree Received:

Date of Graduation (mm/yy)

Mailing Address:

City:

State & Country

ZIP:

X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

Institution:

Program Director:

Mailing Address:

City:

State & Country:

ZIP:

Type of Internship:

Specialty:

From: (mm/yy)

To: (mm/yy)

XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution:

Program Director:

Mailing Address:

City:

State & Country:

ZIP:

Type of Training (e.g. residency, etc)

Specialty:

From: (mm/yy)

To: (mm/yy)

Did you successfully complete the program?

 Yes No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
 Yes No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
 Yes No (If "No", please explain on separate sheet.)

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	Specialty:	Certification Number:	Date Certified/ Rectified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above?
 Yes No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? If Yes, Provide details.
 Yes No

XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:	
Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain on separate sheet			
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):		Date Issued:	Valid Through:
Visa Number:		Date Issued:	Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:	

XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

State	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No

XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Are you an Officer or Director of any of the professional organizations listed above?

If Yes, please list:

Yes No

XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ()	Fax Number: ()	
Per Claim Amount: \$	Aggregate Amount: \$	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	
If you do not have hospital privileges, please explain.		

B. PREVIOUS AFFILIATIONS (Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of other Hospital/institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice/Employer:	Contact Name:	Telephone Number: ()
		Fax Number: ()
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Section B.
Professional Liability Action Explanation

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

I. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:
 Hospital My office Other doctor's office Surgery Center
 Other, (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.): _____

Allegation: _____

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? Yes No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: _____ Phone Number: _____
 Name: _____ Phone Number: _____

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)

Lawsuit/arbitration still ongoing, unresolved.
 Judgement rendered and payment was made on my behalf. Amount paid on my behalf: _____
 Judgement rendered and I was found not liable.
 Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
 Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

SECTION C. *Certification*

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is not Acceptable)

Section D. Attestation Questions

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?
Yes No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?
Yes No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?
Yes No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?
Yes No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?
Yes No
6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?
Yes No
7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?
Yes No
8. Have you ever been convicted of any crime (other than a minor traffic violation)?
Yes No
9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)
Yes No
10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?
Yes No
11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?
Yes No
12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?
Yes No
13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)
Yes No
14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services?
Yes No

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is Not Acceptable)

Section E.
Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”) by and between “this Managed Care Entity” and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. “Healthcare Organizations”), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here: _____

Physician Signature: _____ Date _____
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:
● *Mississippi Association of Health Plans*
● *Mississippi State Medical Association*
● *Mississippi Hospital Association*

³ The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

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 ▶
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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,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

Limited liability company (LLC). Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business name” line.

Other entities. Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the “Exempt payee” box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

**DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT**

This **PARTICIPATING PROVIDER AGREEMENT** (hereinafter “Agreement”) is entered into by and between **DAVIS VISION, INC.**, (hereinafter “**DAVIS**”) having its principal place of business located at 159 Express Street, Plainview, New York 11803 and **PARTICIPATING PROVIDER** (hereinafter “**PROVIDER**”) as defined herein below, and collectively referred to as the “Parties”.

RECITALS

WHEREAS, DAVIS has entered into or intends to enter into agreements (hereinafter “Plan Contract(s)”) with health maintenance organizations, Medicare Advantage Program organizations, Medical Assistance Program organizations, and other purchasers of vision care services (hereinafter “Plan(s)”); and

WHEREAS, DAVIS has established or shall establish a network of participating vision care providers (hereinafter “Network”) to provide, or to arrange for the provision of, or in order to grant access to the vision care services of the Network to individuals (hereinafter “Members”) who are enrolled as Members of such Plans; and

WHEREAS, the Parties desire to enter into this Agreement whereby **PROVIDER** agrees (upon satisfying all Network participation criteria) to provide certain vision care services (hereinafter “Covered Services”) on behalf of **DAVIS** to Members of Plans under Plan Contract(s) with **DAVIS**.*

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, and intending to be bound hereby, the Parties agree as follows:

**I
PREAMBLE AND RECITALS**

.1 The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

**II
DEFINITIONS**

.1 “**Centers for Medicare and Medicaid Services**” (hereinafter “**CMS**”) means the division of the United States Department of Health and Human Services, formerly known as the Health Care Financing Administration (HFCA) or any successor agency.

.2 “**Clean Claim**” means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS**, referencing a specific Member and Member’s information; (b) a valid, **DAVIS**-assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pending or denied until all information is received from the **PROVIDER** and/or Member. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax identification number not documented on a properly completed W-9 form are not Clean Claims.

.3 “**Copayment**” or “**Deductible**” means those charges for vision care services, which shall be collected directly by **PROVIDER** from Member as payment, in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Member’s benefit program.

.4 “**Covered Services**” means, except as otherwise provided in the Member’s benefit plan, a complete and routine eye examination including, but not limited to, visual acuities, internal and external examination, (including dilation where professionally indicated,) refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and when authorized by state law and covered by a Plan, medical eye care, diagnosis, treatment and eye care management services, and when applicable, ordering and dispensing plan eyeglasses from a **DAVIS** laboratory.

.5 “**Generally Accepted Standards of Medical Practice**” means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas and any other relevant factor as determined by statute(s) and/or regulation(s).

.6 “**Managed Care Organization**” (hereinafter “MCO”) means an entity that has or is seeking to qualify for a comprehensive risk contract and that is: (1) a Federally qualified HMO that meets the advance directives requirements of 42 CFR §489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are accessible to other recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR §438.116.

.7 “**Medicaid**” means the joint Federal and State program providing medical assistance to low income persons pursuant to 42 U.S.C. §1369 et seq.

.8 “**Medical Assistance Program**” (hereinafter “MAP”) means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1396 et seq., as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.9 “**Medical Necessity**” / “**Medically Necessary Services.**” With respect to the Medicaid and/or Medical Assistance Programs (MAP), “Medical Necessity” or “Medically Necessary Services” are those services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical

practice and generally recognized by the medical scientific community as effective. A course of treatment may include mere observation or where appropriate no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not Medically Necessary Services for purposes of this Agreement.

Medically Necessary Services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance. In the case of pediatric Members/enrollees, the definition herein shall apply with the additional criteria that the services, including those found to be needed by a pediatric Member as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily Covered Services for all other Medicaid Members are appropriate for the age and health status of the individual, and the service will aid the overall physical and mental growth and development of the individual, and the service will assist in achieving or maintaining functional capacity.

.10 **“Medical Necessity” / “Medically Necessary” / “Medically Appropriate.”** With respect to the Medicare and/or Medicare Advantage Program, in order for services provided to be deemed Medically Necessary or Medically Appropriate, Covered Services must: (1) be recommended by a **PROVIDER** who is treating the Member and practicing within the scope of her/his license and (2) satisfy each and every one of the following criteria:

- (a) The Covered Service is required in order to diagnose or treat the Member’s medical condition (the convenience of the Member, of the Member’s family or of the Participating Provider is not a factor to be considered in this determination); and
- (b) The Covered Service is safe and effective: (i.e. the Covered Service must)
 - (i) be appropriate within generally accepted standards of practice;
 - (ii) be efficacious, as demonstrated by scientifically supported evidence;
 - (iii) be consistent with the symptoms or diagnosis and treatment of the Member’s medical condition; and
 - (iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and
- (c) The Covered Service is the least costly alternative course of diagnosis or treatment that is adequate for the Member’s medical condition; factors to be considered include, but are not limited, to whether the Covered Service can be safely provided for the same or lesser cost in a medically appropriate alternative setting; and
- (d) The Covered Service, or the specific use thereof, for which coverage is requested is not experimental or investigational. A service or the specific use of a service is investigational or experimental if there is not adequate, empirically-based, objective, clinical scientific evidence that it is safe and effective. This standard is not met by (i) a Participating Provider’s subjective medical opinion as to the safety or efficacy of a service or specific use or (ii) a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating a different condition. Use of a drug or biological product that has not received FDA approval is experimental. Off-label use of a drug or biological product that has received FDA approval is experimental unless such off-label use is shown to be widespread and generally accepted in the medical community as an effective treatment in the setting and condition for which coverage is requested.

.11 “**Medically Appropriate/Medical Necessity.**” With respect to Plans other than Medicare, Medicare Advantage and Medicaid, the term “Medically Appropriate” means or describes a vision care service(s) or treatment(s) that a **PROVIDER** hereunder, exercising **PROVIDER**’s prudent, clinical judgment would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the “Generally Accepted Standards of Medical Practice”; and is clinically appropriate in terms of type, frequency, extent site and duration; and is considered effective for the Member’s illness, injury or disease; and is not primarily for anyone’s convenience; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the Member’s illness, injury, or disease.

.12 “**Medicare**” means the Federal program providing medical assistance to aged and disabled persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq., as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.13 “**Medicare Advantage Member**” means a Member who is enrolled in and covered under a Medicare Advantage Program.

.14 “**Medicare Advantage Program**” means a product established by Plan pursuant to a contract with the CMS which complies with all applicable requirements of Part C of Title 42 of United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq., as amended from time to time, and which is available to individuals entitled to and enrolled in Medicare or any successor program(s) thereto regardless of the name(s) thereof.

.15 “**Member**” or “**Enrollee**” means an individual and the eligible dependents of such an individual who is enrolled in or who has entered into contract with or on whose behalf a contract has been entered into with Plan(s), and who is entitled to receive Covered Services.

.16 “**Negative Balance**” means receipt of Copayments, Deductibles or other compensation by **PROVIDER** or Participating Provider which are in excess of the amounts that are due to **PROVIDER** or Participating Provider for Covered Services under this Agreement. When a Negative Balance occurs, **DAVIS** has the right to offset future compensation owed to **PROVIDER** or Participating Provider with the amount owed to **DAVIS** and the right to bill **PROVIDER** or Participating Provider for such Negative Balance(s). **DAVIS** will automatically, when possible, apply the Negative Balance to other outstanding payables on **PROVIDER**’s account. In some instances it may be necessary for **DAVIS** to send an invoice to **PROVIDER** for outstanding Negative Balance(s). The **PROVIDER** is responsible to remit payment to **DAVIS** upon receipt of invoice. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS**’ network in accordance with the suspension and termination provisions set forth in this Agreement. A Negative Balance shall not mean an Overpayment as defined herein.

.17 “**Network**” means the arrangement of Participating Providers established to service eligible Members and eligible dependents enrolled in or who have entered into contract with, or on whose behalf a contract has been entered into with Plan(s).

.18 “**Non-Covered Services**” means those vision care services which are not Covered Services under Plan Contract(s).

.19 “**Overpayment**” means an incorrect claim payment made to a **PROVIDER** or Participating Provider via check or wire transfer due to one or more of the following reasons: (i) a **DAVIS**

processing error (ii) an incorrect or fraudulent claim submission by **PROVIDER** or Participating Provider (iii) a retroactive claim adjustment due to a change, oversight or error in the implementation of a fee schedule. At **DAVIS'** sole discretion, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment. **PROVIDER** shall be responsible to remit payment on such an Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when possible, automatically apply the Overpayment to other outstanding payables on **PROVIDER'**s account. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS'** network in accordance with the suspension and termination provisions set forth in this Agreement.

.20 "**Participating Provider**" means a licensed health facility which has entered into, or a licensed health professional who has entered into an agreement with **DAVIS** to provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s) and those employed and/or affiliated, independent, or subcontracted optometrists or ophthalmologists who have entered into agreements with **PROVIDER**, who have been identified to **DAVIS** and have satisfied Network participation criteria, and who will provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s). All obligations hereunder that are applicable to **PROVIDER** are and shall be deemed to be applicable as to Participating Provider(s) hereunder.

.21 "**Plan(s)**" means a health maintenance organization, corporation, trust fund, municipality, or other purchaser of vision care services that has entered into a Plan Contract with **DAVIS**.

.22 "**Plan Contract(s)**" means the agreements between **DAVIS** and Plans to provide for or to arrange for the provision of vision care services to individuals enrolled as Members of such Plans.

.23 "**Provider Manual**" means the **DAVIS** Vision Care Plan Provider Manual, as amended from time to time by **DAVIS**.

.24 "**State**" means the State in which **PROVIDER'**s practice is located or the State in which the **PROVIDER** renders services to a Member.

.25 "**United States Code of Federal Regulations**" (hereinafter "CFR") means the codification of the general and permanent rules and regulations published in the Federal Register by the executive department and agencies of the federal government.

.26 "**United States Department of Health and Human Services**" (hereinafter "DHHS") means the executive department of the federal government which provides oversight to the Centers for Medicare and Medicaid Services (CMS).

.27 "**Urgently Needed Services**" means Covered Services that are not emergency services as defined in 42 CFR §422.113 provided when a Member is temporarily absent from the Medicare Advantage Program Plan's service area (or if applicable, continuation area) or, under unusual and extraordinary circumstances, Covered Services provided when the Member is in the service or continuation area but the Network is temporarily unavailable or inaccessible and when the Covered Services are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition; and it was not reasonable, given the circumstances, to obtain the Covered Services through the Medicare Advantage Plan Network. "**Stabilized Condition**" means a condition whereby the physician treating the Member must decide when the Member may be considered stabilized for transfer or discharge, and that decision is binding on the Plan.

III SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Frame Collection.** As a bailment, **and if applicable, PROVIDER** shall maintain the selection of Plan approved frames in accordance with the Provider Manual and as set forth herein:

- (a) **PROVIDER** agrees the frame collection will be shown to all Members receiving eyeglasses under the Plan.
- (b) **PROVIDER** agrees the frame collection shall be openly displayed in an area accessible to all Members.
- (c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was delivered less any normal deterioration.
- (d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.
- (e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and at any other time upon reasonable notice. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.
- (f) At any time and upon reasonable notice **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.
- (g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume the full cost of the display and/or the frame collection and will be required to reimburse **DAVIS** its/their fair market value.

.2 **Open Clinical Dialogue.** Nothing contained herein shall be construed to limit, prohibit or otherwise preclude **PROVIDER** from engaging in open clinical dialogue with any Member(s) or any designated representative of a Member(s) regarding: (a) any Medically Necessary or Medically Appropriate care, within the scope of **PROVIDER**'s practice, including but not limited to, the discussion of all possible and/or applicable treatments, including information regarding the nature of treatment, risks of treatment, alternative treatments or the availability of alternative treatments or consultations and diagnostic test, and regardless of benefit coverage limitations under the terms of the Plan(s)' documents or medical policy determinations and whether such treatments are Covered Services under the applicable **DAVIS** benefit program designs; or (b) the process **DAVIS** uses on its own behalf or on behalf of Plan(s) to deny payment for a vision care service; or (c) the decision by **DAVIS** on its own behalf or on behalf of Plan(s) to deny payment for a vision care service.

.3 **Services.** **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO. Throughout the entire Term(s) of this Agreement, **PROVIDER** shall maintain, in good working condition, all necessary diagnostic equipment in order to perform all Covered Services as defined in this Agreement.

(a) To the extent required by law, **DAVIS** and/or Plan(s) will provide coverage of Urgently Needed Services to Members of a Medicare Advantage Program and where applicable, **DAVIS** shall reimburse **PROVIDER** for Urgently Needed Services rendered to Member(s) in order to attain Stabilized Condition and in accordance with applicable laws, administrative requirements, CMS regulations (42 CFR §422.113) and without regard to prior authorization for such services. **PROVIDER** also agrees to notify **DAVIS** of Urgently Needed Services and any necessary follow-up services rendered to any Member(s).

.4 **Scope of Practice.** The Parties acknowledge and agree nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

.4.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

.4.2 Any information the Member needs in order to decide among all relevant treatment options;

.4.3 The risks, benefits, and consequences of treatment versus non-treatment;

.4.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions;

.4.5 Information or opinions regarding the terms, requirements or services of the health care benefit plan as they relate to the medical needs of the patient; and

.4.6 The termination of **PROVIDER**'s agreement with the MCO or the fact that the **PROVIDER** will otherwise no longer provide vision care services under the **DAVIS** Plan Contract(s) with MCO.

.5 **Treatment Records.** **PROVIDER** shall (1) establish and maintain a treatment record consistent in form and content with generally accepted standards and the requirements of **DAVIS** and Plan(s); and (2) promptly provide **DAVIS** and Plan(s) with copies of treatment records when requested; and (3) keep treatment records confidential. Treatment records shall be kept confidential, but **DAVIS** and/or Plans shall have a mutual right to a Member's treatment records, as well as timely and appropriate communication of Member information, so that both the **PROVIDER** and Plans may perform their respective duties efficiently and effectively for the benefit of the Member.

IV COMPENSATION

.1 **Compensation.** **DAVIS** shall pay **PROVIDER** the compensation amounts that are communicated from time to time by **DAVIS** to **PROVIDER**. Such compensation amounts are hereby incorporated by reference. Such compensation amounts are and shall be deemed to be full compensation for the Covered Services provided by **PROVIDER** to Members under applicable Plan(s) pursuant to this Agreement.

.2 **Copayments, Deductibles and Discount.** **PROVIDER** shall bill and collect all Copayments and Deductibles from Member(s), which are specifically permitted and/or applicable to Member(s)' benefit plan. **PROVIDER** shall bill and collect all charges from a Member for those Non-

Covered Services provided to a Member. **PROVIDER** may only bill the Member when **DAVIS** has denied prior authorization for the service(s) and when the following conditions are met:

(a) The Member has been notified by the **PROVIDER** of the financial liability in advance of the service delivery;

(b) The notification by the **PROVIDER** is in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement which is signed by all patients is not sufficient for this purpose;

(c) The notification is dated and signed by the Member; and

(d) To the extent permitted by law, **PROVIDER** shall provide to Members either a courtesy discount of twenty percent (20%) off of **PROVIDER**'s usual and customary fees for the purchase of materials not covered by a Plan(s), and/or a discount of ten percent (10%) off of **PROVIDER**'s usual and customary fees for disposable contact lenses.

.3 **Financial Incentives.** **DAVIS** shall not provide **PROVIDER** with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the Parties hereto agree to comply with and to be bound by, to the same extent as if the sections were restated in their entirety herein, the provisions of 42 CFR §417.479 and 42 CFR §434.70, as amended by the final rule effective January 1, 1997, and as promulgated by the CMS (formerly the Health Care Financing Administration, DHHS). In part, these sections govern physician incentive plans operated by federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42 CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder to a physician or physician group, as an inducement to reduce or limit medically necessary services furnished to a Member.

.4 **Member Billing/Hold Harmless.** Notwithstanding anything herein to the contrary, **PROVIDER** agrees **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit program, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from Members, persons acting on Member(s)' behalf, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit program. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereinafter entered into between Member(s) or person acting on Member(s)' behalf and **PROVIDER**, which relate to liability for payment; shall survive termination of this Agreement regardless of the reason for termination, shall be construed to be for the benefit of the Member(s) and shall not be changed without the approval of appropriate regulatory authorities.

.5 **Payment of Compensation.** Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS** or in accordance with the applicable state's prompt pay statute, whichever is least restrictive. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Deductible collected or to be collected from the Member. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within sixty (60) days following the provision of Covered Services, submit to **DAVIS** an invoice which, may be written, electronic or verbal; shall be approved as to form and content by **DAVIS**; and

if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit said invoice within sixty (60) days of service delivery will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

(a) **PROVIDER** acknowledges and agrees no specific payment made by **DAVIS** or Plan(s) for services provided under this Agreement is an inducement to reduce or to limit services or products **PROVIDER** determines are Medically Necessary or Medically Appropriate within the scope of **PROVIDER'**s practice and in accordance with applicable laws and ethical standards.

.6 **Plan Hold Harmless Provisions.** **PROVIDER** agrees **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan, the Federal government, and the CMS from any obligation to compensate **PROVIDER** for Covered Services.

V OBLIGATIONS OF PROVIDER

.1 **Access to Records.** To the extent applicable and necessary for **DAVIS** and/or Plan(s) to meet their respective data reporting and submission obligations to CMS, or other appropriate governmental agency; **PROVIDER** shall provide to **DAVIS** and/or Plan(s) all data and information in **PROVIDER'**s possession. Such information shall include, but shall not be limited to the following:

- .1.1 any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and
- .1.2 any information necessary for Plan(s) to administer and evaluate program(s); and
- .1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and
- .1.4 any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies under 42 CFR §422.210; and
- .1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 C.F.R. §§ 422.516 and 422.310, and all other sections of 42 CFR. §422 relevant to reporting obligations; and
- .1.6 **PROVIDER** shall certify (based upon best knowledge, information and belief) the accuracy, completeness and truthfulness of **PROVIDER-**generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to CMS; and
- 1.7 **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER'**s submission or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

.2 **COB Obligation of PROVIDER.** **PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payer(s) such charges for which the other payer(s) is responsible. **PROVIDER** shall report to **DAVIS** all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this paragraph when billing is submitted to **DAVIS** for payment.

.3 **Compliance with Laws and Ethical Standards.** During the Term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable federal, state or municipal statutes or ordinances, including but not limited to, all applicable rules and regulations, all applicable federal and state tax laws, all applicable federal and state criminal laws as well as the customary ethical standards of the appropriate professional society from which **PROVIDER** seeks advice and guidance or to which **PROVIDER** is subject to licensing and control. **PROVIDER** shall comply with all applicable laws and administrative requirements, including but not limited to, Medicaid laws and regulations, Medicare laws, CMS instructions and policies, **DAVIS'** and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures. If at any time during the Term of this Agreement, **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall immediately notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may comply with any requirements imposed by state and federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS Rules.** **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS** including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **DAVIS** shall maintain the Provider Manual to comply with applicable laws and regulations. However, in instances when **DAVIS'** rules are not in compliance, applicable State laws and regulations shall apply. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(a) To the extent that a requirement of the Medicare, Medicare Advantage, or Medicaid Program is found in a policy, manual, or other procedural guide of **DAVIS**, Plan(s), DHHS or other government agency, and is not otherwise specified in this Agreement, **PROVIDER** will comply and agrees to require its employees, agents, subcontractors and independent contractors to comply with such policies, manuals, and procedures with regard to the provision of Covered Services to Members of such Programs.

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements; including but not limited to Medicare and Medicaid laws and regulations, CMS instructions and policies, MAP regulations, and **DAVIS'** and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, activities necessary for the external accreditation of **DAVIS** and/or Plan(s) by the National Committee for Quality Assurance or any other similar organization selected by **DAVIS** and/or Plan(s), peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies. Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP which, on an ongoing basis, shall monitor performance under this Agreement to ensure that performance of the Parties is

consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the State MAP and the MCO.

(c) **PROVIDER** acknowledges and agrees that in relation to the provision of Covered Services to Medicare Advantage Members and Plan(s) hereunder, **PROVIDER**, and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare Advantage credentialing and re-credentialing requirements and processes; Plan(s) are ultimately accountable to CMS; all services delivered and performed by **PROVIDER** hereunder must be accomplished in accordance with the requirements of Plan agreements with CMS and with Medicare laws and regulations; and CMS must audit and oversee Plans' performance on an ongoing basis. **PROVIDER** acknowledges and understands the Medicare Advantage Plan is ultimately responsible to CMS for performance of such services; such services shall be monitored by the Plan(s) and by CMS and/or its delegates; and the Plan(s) and/or CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s).

.5 Confidentiality of Member Information. **PROVIDER** agrees to abide by all Federal and State laws regarding confidentiality, including unauthorized uses of or disclosures of patient information and personal health information.

(a) **PROVIDER** shall safeguard all information about Members according to applicable State and federal laws and regulations. All material and information, in particular information relating to Members or potential Members which is provided due to, or is obtained by or through **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and the securement of **PROVIDER**'s rights under this Agreement.

(b) Neither **DAVIS** nor **PROVIDER** shall share confidential information with any Member(s)' employer, absent the Member(s)' written consent for such disclosure. **PROVIDER** agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange and to the storage of Protected Health Information ("PHI"), as defined by Title 45 of the CFR, Part 160.103 in whatever form or medium **PROVIDER** may obtain and maintain such PHI. **PROVIDER** shall cooperate with **DAVIS** in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

(c) **PROVIDER** and **DAVIS** acknowledge that the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. **PROVIDER** and **DAVIS** agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. **PROVIDER** and **DAVIS** further agree to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER** and **DAVIS** shall conduct good faith negotiations to amend this Agreement.

.6 Consent to Release Information. **PROVIDER** shall provide **DAVIS** with authorizations, consents or releases, as **DAVIS** may request in connection with any inquiry by **DAVIS** of any hospital, educational institution, governmental or private agency or association (including without limitation the National Practitioner Data Bank) or any other entity or individual relative to **PROVIDER**'s professional qualifications, **PROVIDER**'s mental or physical fitness, or the quality of care rendered by **PROVIDER**.

.7 Cooperation with Plan Medical Directors. **PROVIDER** understands that Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and that Plans in

certain instances will have the right to oversee and review the quality of care administered to Members. **PROVIDER** agrees to cooperate with Plan(s)' medical directors in the medical directors' review of the quality of care administered to Members.

.8 **Credentialing, Licensing and Performance.** **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees he/she/it shall be duly licensed by the state in which services are to be rendered, shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE), and shall participate in such programs of continuing education required by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS** and Plan(s). Such documentation shall include, but shall not be limited to proof of: National Provider Identifier Number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS'** sole option, the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall **immediately notify DAVIS, in writing**, in the event **PROVIDER** suffers a suspension or a termination of license or professional liability insurance coverage. **PROVIDER** shall; devote the time, attention and energy necessary for the competent and effective performance of duties hereunder to Member(s); use best efforts to ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices; and abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

.9 **Fraud/Abuse and Office Visits.** Upon the request of the CMS, the DHHS, the MAP, or any appropriate external review organization or regulatory agency ("Oversight Entities") **PROVIDER** shall make available for audit, all administrative, financial, medical, and all other records that relate to the delivery of items or services under this Agreement. **PROVIDER** shall provide all such access to the aforementioned records in the form and format requested and at no cost to **DAVIS** and/or to the requesting Oversight Entity. Further, the **PROVIDER** shall cooperate with and allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hour access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity.

.10 **Hours and Availability of Services.** Pursuant to and in accordance with 42 CFR §438.206(c)(1), **PROVIDER** and Participating Provider(s) agree to be available to provide Covered Services for Medically Appropriate care, taking into account the urgency of the need for services and when necessary and appropriate, to provide Covered Services for Medically Appropriate emergency care. **PROVIDER** and Participating Provider(s) shall ensure that Members will have access to either an answering service, a pager number, and/or an answering machine, twenty-four (24) hours per day, seven (7) days per week, in order that Members may ascertain **PROVIDER's** office hours, have an opportunity to leave a message for the **PROVIDER** and/or Participating Provider(s) regarding a non-emergent concern and to receive pre-recorded instructions with respect to the handling of an emergency.

(a) **PROVIDER** agrees **PROVIDER** is subject to regular monitoring of his/her/its compliance with the appointment wait time (timely access) standards of 42 CFR §438.206(c)(1). As such **PROVIDER** agrees and understands that corrective action shall be implemented should **PROVIDER** and/or Participating Provider(s) fail to comply with timely access standards and that Plan(s) have the right to approve **DAVIS'** scheduling and administration standards.

(b) **PROVIDER** agrees to provide **DAVIS** with thirty (30) calendar days notice if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/its office location, (c) change his/her/its place of employment (d) change his/her/its employer, or (e) reduce capacity at an office location. The thirty (30) calendar day notice shall, at a minimum, include the effective date of the change, the new tax identification number and a copy of the W-9 as applicable, the name of the new practice, the name of the contact person, the address, telephone and fax numbers and other such information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Provider to **DAVIS**. Under no circumstance shall the provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER** and **DAVIS**.

.11 **Indemnification.** **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

(a) To the extent applicable, **PROVIDER** agrees to indemnify and hold harmless the State and the CMS from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the State or the CMS as a result of a failure of **PROVIDER** or **PROVIDER**'s agents, employees, subcontractors or independent contractors to comply with the Non-Discrimination provisions contained in Section V.13 herein.

.12 **Malpractice Insurance.** **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire Term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars (\$1,000,000.00) per occurrence and Three Million Dollars (\$3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER**'s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits. The foregoing policies shall not limit **PROVIDER**'s ability to indemnify the State or enrollees of a Medical Assistance Program.

(a) **PROVIDER** shall cause his/her/its employed, affiliated, independent or subcontracted Participating Provider(s) to substantially comply with Article V.12 above, and throughout the Term of this Agreement and upon **DAVIS**' request, **PROVIDER** shall provide evidence of such compliance to **DAVIS**.

.13 **Nondiscrimination.** Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall comply with the "General Prohibitions Against Discrimination," 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the regulations implementing the Americans with Disabilities Act ("ADA"), 28 CFR §35.101 et seq., **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence),

claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of Federal funds including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (“Revised DHHS LEP Guidance”); and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the Term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee’s or applicant’s hire, tenure, terms, conditions, or privileges of employment due to such individual’s race, color, religion, gender, disability, marital status or national origin.

.14 **Notice of Non-Compliance and Malpractice Actions.** **PROVIDER** shall notify **DAVIS** immediately, in writing, should **PROVIDER** be in violation of any portion of this Section V. Additionally, **PROVIDER** shall advise **DAVIS** of each malpractice claim filed against **PROVIDER** and each settlement or other disposition of a malpractice claim entered into by **PROVIDER** within fifteen (15) days following said filing, settlement or other disposition.

.15 **Participation Criteria.** **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of his/her/its employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal laws designed to prevent fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§422.504(h)(1), 423.505(h)(1). **PROVIDER** hereby warrants and represents **PROVIDER** and all of **PROVIDER**’s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier number.

(a) **PROVIDER** understands and agrees meeting the Participation Criteria is a condition precedent to **PROVIDER**’s participation, and a condition precedent to the participation by **PROVIDER**’s employees, affiliates, subcontractors, and/or independent contractor(s) hereunder and, is an ongoing condition to the provision of Covered Services hereunder by both the **PROVIDER** as well as a condition precedent to the reimbursement by **DAVIS** for such Covered Services rendered by **PROVIDER**. Upon **PROVIDER**’s meeting all of the Participation Criteria set forth in this Agreement **PROVIDER** shall participate as a Participating Provider for Plan(s)/programs covered under this Agreement.

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges and understands this Agreement shall automatically be terminated if **PROVIDER**, any practitioner, or any person with an ownership or control interest in **PROVIDER**, is excluded from participation in Medicare under Section 1128 or 1128A of the

Social Security Act or from participation in any other federal health care program. Any payments received by **PROVIDER** hereunder on or after the date of such exclusion shall constitute overpayments.

.16 **PROVIDER Roster.** **PROVIDER** agrees **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER**'s name, address, telephone number, type of practice, and willingness to accept new patients in the **DAVIS** or in the Plan roster of Participating Provider(s). The roster is intended for and may be inspected and used by prospective patients and others.

.17 **Record Retention.** **PROVIDER** shall maintain adequate and accurate medical, financial and administrative records related to Covered Services rendered by **PROVIDER** in accordance with federal and State law. **PROVIDER** shall have written policies and procedures for storing all records.

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to maintain, in an accurate and timely manner, and to safeguard contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agrees to provide such information to **DAVIS**, contracting Plans, applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. **PROVIDER** shall make available premises, physical facilities, equipment, records and any relevant information the CMS may require which pertains to Covered Services provided to Medicare Advantage Program Members. **PROVIDER** and Participating Provider(s) shall cooperate with any such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and shall make appropriate practitioner(s), employees, and involved parties available for interviews, as requested. Such records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

(b) All hard copy or electronic records, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, which are originated or are prepared in connection with and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicaid program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the federal and State regulations. Records stored electronically must be produced at the **PROVIDER**'s expense, upon request, in the format specified by State or federal authorities. All such records must be maintained for a minimum of six (6) years from the termination date of this Agreement or, in the event that the **PROVIDER** has been notified that State or federal authorities have commenced an audit or investigation of this Agreement, or of the provision of services by the **PROVIDER**, or by **PROVIDER**'s subcontractor or independent contractor, all records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

(c) **PROVIDER**'s obligations contained in Section V.17 herein shall survive termination of this Agreement.

.18 **Subcontractors.** **PROVIDER** agrees that in no event shall **PROVIDER** or Participating Provider(s) enter into subcontracts or lease arrangements with any person or entity outside of the jurisdiction of the United States (“offshore subcontractor”) for the purpose of rendering vision care services to Medicare/Medicare Advantage Members covered under this Agreement without the prior, written approval of **DAVIS**, the Medicare Advantage Plan and CMS. Failure to obtain prior approval may result, at the discretion of **DAVIS** or Plan, in the immediate termination of **PROVIDER** and/or Participating Provider(s). **PROVIDER** agrees if **PROVIDER** enters into any permitted subcontracts or lease arrangements to render any health/vision care services permitted under the terms of this Agreement, **PROVIDER**’s subcontracts or lease arrangements shall include the following:

- (a) an agreement by the subcontractor or leaseholder to comply with all of **PROVIDER**’s obligations in this Agreement; and
- (b) a prompt payment provision as negotiated by **PROVIDER** and the subcontractor or leaseholder; and
- (c) a provision setting forth the terms of payment, any incentive arrangements, and any additional payment arrangements; and
- (d) a provision setting forth the term of the subcontract or lease (preferably a minimum of one [1] year); and
- (e) the dated signature of all parties to the subcontract.

.19 **Training Regarding the Plan Contracts.** **PROVIDER** agrees to train his/her/its Participating Providers and staff at all duly credentialed **PROVIDER** offices regarding the fees and benefit or plan designs for Plan Contracts.

.20 **Verification of Eligibility.** **PROVIDER** shall verify eligibility of Member(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS**, or by accessing the **DAVIS** website (www.davisvision.com), or by receiving from Member(s) a valid pre-certified voucher.

VI TERM OF THE AGREEMENT

.1 **Term.** This Agreement shall become effective on the Effective Date appearing on the signature page herein, and shall thereafter be effective for an initial Term of twelve (12) months.

.2 **Renewals.** Unless this Agreement is terminated in accordance with the termination provisions herein, this Agreement shall automatically renew for up to, but not more than, three (3) successive twelve (12) month Terms on the same terms and conditions contained herein.

VII TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause.** After the initial twelve (12) month Term has ended, this Agreement may be terminated by either Party without cause, upon ninety (90) days prior, written notice. If **DAVIS** elects to terminate this Agreement other than at the end of the initial Term hereof, or for a reason other than those set forth in Sections VII.1 and VII.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**’s request or within such time as is required by applicable law or regulation.

.2 **Termination With Cause.** **DAVIS** may terminate this Agreement immediately for cause or may suspend continued participation as set forth below. “Cause” shall mean:

(a) a suspension, revocation or conditioning of **PROVIDER**'s license to operate or to practice his/her/its profession;

(b) a suspension, or a history of suspension, of **PROVIDER** from Medicare or Medicaid;

(c) conduct by **PROVIDER** which endangers the health, safety or welfare of Members;

(d) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement, to include but not be limited to fraud;

(e) a conviction of a felony;

(f) a loss or suspension of a Drug Enforcement Administration (DEA) identification number;

(g) a voluntary surrender of **PROVIDER**'s license to practice in any state in which the **PROVIDER** serves as a **DAVIS** Provider while an investigation into the **PROVIDER**'s competency to practice is taking place by the state's licensing authority;

(h) the bankruptcy of **PROVIDER**.

“Cause” for the purposes of suspension shall mean:

(a) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section V.12 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.3 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS**' rules and regulations as required in Section V.4 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section IX.3 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.8 hereof;

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated or suspended because **PROVIDER** acts as an advocate for a Member in seeking appropriate Covered Services, or files a complaint or an appeal.

.3 **Termination Related to Medicare Advantage.** At the sole discretion of the CMS, Plan(s) and/or **DAVIS**, this Agreement may be immediately terminated, as it relates to **PROVIDER**'s provision of Covered Services to Medicare Advantage Members hereunder for the following reasons:

.3.1 The termination is for breach of contract, or there is a determination of fraud; or

.3.2 In the opinion of **DAVIS'** medical director or its equivalent, the health care professional represents an imminent danger to an individual patient or the public health, safety or welfare; or

.3.3 A decision by the CMS, Plan(s), and/or **DAVIS** that: (i) **PROVIDER** has not performed satisfactorily, or (ii) **PROVIDER'**s reporting and disclosure obligations under this Agreement are not fully met or timely met; or

.3.4 The failure of **PROVIDER** to comply with the equal access and non-discrimination requirements set forth in this Agreement.

.4 **Responsibility for Members at Termination**. In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement for a minimum transitional period of sixty (60) days from the date the Member is notified of the termination or pending termination, or until the Covered Services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Member), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date of this Agreement) at the rates contemplated for Covered Services in this Agreement.

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the Parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

(b) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement, **PROVIDER** acknowledges and agrees **PROVIDER'**s obligations as set forth in this Section VII survive such termination.

.5 **PROVIDER Rights Upon Termination**. Except as otherwise required by law, **PROVIDER** agrees, subject to the appeal process set forth in the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final.

(a) **PROVIDER** acknowledges and understands Plan(s) have the authority to determine whether a **PROVIDER** shall be suspended or terminated from participation in a particular Plan without termination of this Agreement. However, Plan(s) shall not have the authority to terminate **PROVIDER** for (a) maintaining a practice that includes a substantial number of patients with expensive health conditions; (b) objecting to or refusing to provide a Covered Service on moral or religious grounds; (c) advocating for Medically Appropriate care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable standard of care; (d) filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; and (e) protesting a Plan decision, policy or practice that **PROVIDER** reasonably believes interferes with the provision of Medically Appropriate care.

.6 **Return of Materials, Payments of Amounts Due and Settlement of Claims.** Upon termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** may reclaim frame samples, with reasonable notice, at any time during the Term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

.7 **Provider Notification to Members upon Termination.** Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should **PROVIDER** move office location, or should a particular practitioner leave **PROVIDER**'s practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify effected Member(s) a minimum of thirty (30) days prior to the effective date of such action or termination.

VIII DOCUMENTATION AND AMENDMENT

.1 **Amendment.** This Agreement may be amended by **DAVIS** with thirty (30) days advance, written notice to **PROVIDER**.

.2 **Documentation.** **DAVIS** shall provide **PROVIDER** with a copy of any document(s) required by contracting Plan(s), which has been approved by **DAVIS** and requires **PROVIDER**'s signature. If **PROVIDER** does not execute and return said document(s) within fifteen (15) calendar days of document receipt, or if **PROVIDER** does not provide **DAVIS** with a written notice of termination in accordance with the termination provision(s) contained herein, **DAVIS** may execute said document(s) as agent of **PROVIDER** and said document(s) shall be deemed to be executed by **PROVIDER**.

.3 **Modification of Law, Rules, Regulations.** Notwithstanding anything herein to the contrary, should any applicable federal or State law(s) be amended and their implementing regulations, policy issuances and instructions be modified, no particular notice of amendment by **DAVIS** to **PROVIDER** shall be required. Such amended laws apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without the necessity for executing written amendments. **DAVIS** shall however, employ its best efforts to notify **PROVIDER** of such occurrences within a practicable timeframe.

.4 **Upon Request of CMS.** Upon request of the CMS, this Agreement and any addenda may be amended to exclude any Medicare Advantage Program Plan or State-licensed entity specified by the CMS. When such a request is made, a separate contract for any such excluded Plan or entity will be deemed to be in place.

IX UTILIZATION REVIEW, QUALITY MANAGEMENT, QUALITY IMPROVEMENT AND GRIEVANCE PROCEDURES

.1 **Access to Records.** **PROVIDER** shall make all records available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

(a) **Upon termination** of this Agreement for any reason, **PROVIDER** shall, in a useable form, make available to any Oversight Entities, all records, whether dental/medical or financial, related to

PROVIDER's activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.

.2 **Consultation with Provider.** **DAVIS** agrees to consult with **PROVIDER** regarding **DAVIS**' medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines:

(a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(b) consider the needs of the enrolled population;

(c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and

(d) are communicated to Participating Providers of the Plan(s) and as appropriate to the Members.

With respect to utilization management, Member education, coverage of health care services, and other areas in which guidelines apply, **DAVIS** shall ensure decisions are consistent with applicable guidelines.

.3 **Establishment of UR/QM Programs.** Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, in its sole and absolute discretion, and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER**'s rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this paragraph may be deemed by **DAVIS** to be a material breach of this Agreement and may, at **DAVIS**' option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment hereunder for those Covered Services provided to a Member which are determined to not be Medically Appropriate or of poor quality or to be services for which **PROVIDER** failed to receive a prior authorization to treat a Member.

.4 **Grievance Procedures.** Subject to **PROVIDER**'s rights of appeal, **PROVIDER** shall comply and be bound by the grievance procedure which, in the sole discretion of **DAVIS** and Plan(s) shall be established in accordance with applicable statutes and their implementing regulations for the processing of any patient or **PROVIDER** complaint regarding Covered Services. From time to time, should the grievance procedure require modification whether by **DAVIS** or Plan(s), it shall be modified in accordance with applicable regulations and Section V.4 "Compliance with **DAVIS** Rules" herein.

.5 **Provider Cooperation with External Review.** **PROVIDER** shall cooperate and provide Plans, **DAVIS**, government agencies and any external review organizations ("Oversight Entities") with access to each Member's vision records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member(s)' complaints or grievances or as otherwise is necessary or appropriate.

.6 **Provider Participation/Cooperation with UR/QM Programs.** As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures

and activities; and utilization and management review; care coordination activities including, but not limited to, medical record reviews, HEDIS reporting, disease management programs, case management, clinical practice guidelines, and other quality measurements to improve Members' care. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and Medical Assistance Program Members. **PROVIDER** shall implement a continuous quality improvement action plan if areas for improvement are identified.

X GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the Parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing Party.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and to their respective heirs, legal representatives, successors, and permitted assigns. Notwithstanding the foregoing, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS'** assets.

.3 **Confidentiality of Terms/Conditions**. The terms of this Agreement and in particular the provisions regarding compensation are confidential and shall not be disclosed except as and only to the extent necessary to the performance of this Agreement or as required by law.

.4 **Conformity of Law**. Any provision of this Agreement which conflicts with the state or federal law is hereby amended to conform to the requirements of such law.

.5 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the Parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the Parties with respect to the rendering of Covered Services. Each Party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by either Party, or anyone acting on behalf of either Party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing and signed by the Party to be charged.

.6 **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the state in which **PROVIDER** maintains his, her, or its principal office or, if a dispute concerns a particular Member, in the state in which **PROVIDER** rendered services to that Member.

.7 **Headings**. The subject headings of the sections and sub-sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of the provisions of this Agreement.

.8 **Independent Contractor**. At all times relevant to and pursuant to the terms and

conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER**'s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

.9 **Non-Solicitation of Members**. During the Term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Members, Plans or any employer of said Members without **DAVIS**' prior written consent. For purposes of this Agreement, a solicitation shall mean any action by **PROVIDER** which **DAVIS** may reasonably interpret to be designed to persuade or encourage (i) a Member or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Member or an employer of any Member to disenroll from a Plan contracting with **DAVIS**. A breach of this paragraph shall be grounds for immediate termination of this Agreement.

.10 **Notices**. Should either Party be required or permitted to give notice to the other Party hereunder, such notice shall be given in writing and shall be delivered personally or by first class mail to the addresses appearing herein. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Either Party may change its address by providing written notice in accordance with this paragraph.

.11 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Member, including but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Member Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the Term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express prior written permission of **DAVIS**, the Plan in which the Member is enrolled, and the Member.

.12 **Severability**. Should any provision of this Agreement be held to be invalid, void or unenforceable by a court of competent jurisdiction or by applicable state or federal law and their implementing regulations, the remaining provisions of this Agreement will nevertheless continue in full force and effect.

.13 **Third Party Beneficiaries**.

(a) **Plans**. Plans are intended to be third party beneficiaries of this Agreement. Plans shall be deemed, by virtue of this Agreement to have privity of contract with **PROVIDER** and may enforce any of the terms hereof.

(b) **Other Persons**. Other than the Plans and the Parties hereto and their respective successors or assigns, nothing in this Agreement whether express or implied, or by reason of any term, covenant, or condition hereof, is intended to or shall be construed to confer upon any person, firm, or corporation, any remedy or any claim as third party beneficiaries or otherwise; and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the Parties hereto and their successors and assigns.

.14 **Use of Name.** **PROVIDER** shall not use **DAVIS'** or any Plan's name or logo without the written authorization of **DAVIS** or such Plan.

.15 **Waiver.** The waiver of any provision or the waiver of any breach of this Agreement must be set forth specifically in writing and signed by the waiving Party. Any such waiver shall not operate as or be deemed to be a waiver of any prior or any future breach of such provision or of any other provision contained herein.

-SIGNATURE PAGE TO FOLLOW-

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

IN WITNESS WHEREOF, the Parties have set their hand hereto and this Agreement is effective as of the Effective Date written below.

PROVIDER:

Signature: _____
Print Name: _____
Print Title: _____
Print Date: _____
Print Address [**PROVIDER's** complete location address]: _____

(PROVIDER MUST sign and complete all spaces below PROVIDER signature.)

* Submission of a completed credentialing application and/or submission of a signed Participating Provider Agreement does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's fully and properly completed credentialing application and on the execution by practitioner of the Participating Provider Agreement and on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following **DAVIS'** acceptance of a practitioner as a Participating **PROVIDER**, should additional licensed and credentialed practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Plan Contract(s) with **DAVIS**, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement to the same extent as the original signatories to this Agreement.

DAVIS VISION, INC.:

Signature: _____
Print Name: _____
Print Title: _____
Date: _____

Effective Date: _____
[For **DAVIS** use only]

Notes: _____
[For **DAVIS** use ONLY]