DAVIS VISION
PROVIDER DOCUMENT REQUIREMENTS
FOR THE STATE OF NORTH CAROLINA

Davis Vision's provider credentialing policy requires all applicants/practitioners in the State of North Carolina to **complete and/or forward the following documents** for completion of the credentialing process prior to requesting authorization of services to a Davis Vision plan member.

____________ **APPLICATION**

"North Carolina Department of Insurance Uniform Application to Participate as a Health Care Practitioner."

____________ **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NORTH CAROLINA**

Both the first page and the signature page of the Davis Vision Participating Provider Agreement for the State of North Carolina must be completed and signed by the practitioner/applicant, and a complete copy of the signed Agreement must be forwarded to Davis Vision.

____________ **W-9 FORM** (Request for Taxpayer Identification Number and Certification)

____________ **COPY OF ALL CURRENT STATE REGISTRATIONS**

____________ **COPY OF DEA CERTIFICATE, IF APPLICABLE**

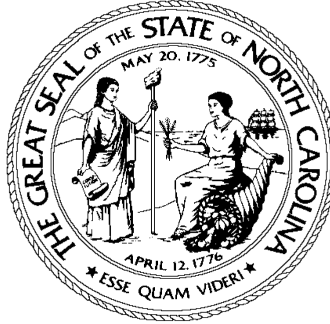
____________ **COPY OF CSR CERTIFICATE, IF APPLICABLE**

____________ **COPY OF BOARD CERTIFICATION, IF APPLICABLE**

____________ **COPY OF CURRICULUM VITAE OR RESUMÉ**

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

____________ **COPY OF BLANK PATIENT EXAM FORM**



North Carolina Department of Insurance

Uniform Application
To Participate as a Health Care Practitioner

Note: Please send completed applications directly to the organizations with which you seek to contract.

The following application is a form approved by the North Carolina Department of Insurance, in accordance with North Carolina General Statute 58-3-230. Every insurer that provides a health benefit plan and credentials providers for its network is required to use this form and the insurer may not require an applicant to submit information that is not required by this form. Only the Commissioner of Insurance is authorized to make changes, deletions or additions to this form.

INSTRUCTIONS

Before submitting the Application, make sure you have completed the following:

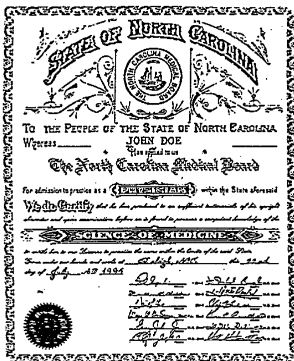
Include an answer in **<u>all</u>** spaces. Indicate “N/A”, if the question is not applicable.
The provider has signed and dated the last page of the Application.

Before submitting the Application, make sure you have <u>enclosed</u> the following, *<u>if applicable</u>*:

Copy of the provider’s <u>original</u> state(s) license(s) and current registration.
Copy of <u>current</u> DEA certificate. (Must have a valid date and refer to current address.)
Copy of South Carolina Controlled Drug Substance Certificate and DEA information.
Copy of the face sheet of your <u>current</u> professional liability insurance policy, indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, and policy number. Attach previous carrier face sheet.
Proof of professional liability insurance for non-physician providers who care for patients in your practice.
Copy of certificate from the Specialty Board.
Copy of Educational Commission of Foreign Medical Graduate Certificate-ECFMG.
Letter(s) of reference, recommendation, and/or oversight, *if required.*
Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school **(CV must account for any gaps of 90 days or more).**
Copy of CLIA (Clinical Laboratory Improvement Amendments) /ACR (American College of Radiology).
Copy of W-9 Form.

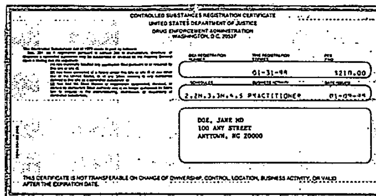
Examples of documentation to attach to this application:

Original N.C. License



State of North Carolina
To the People of the State of North Carolina
Whereas JOHN DOE
The North Carolina Medical Board
Science of Medicine

DEA Registration



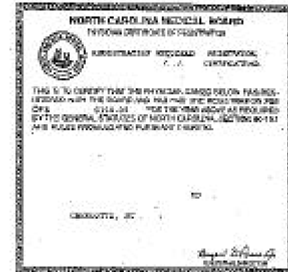
CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

01-31-99 $210.00
2,2N,3,3N,4,5 PRACTITIONER

DOE, JANE MD
100 ANY STREET
ANYTOWN, NC 20000

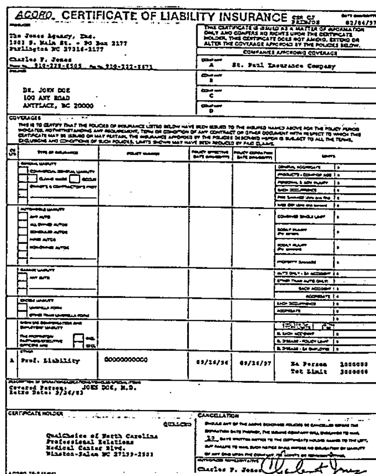
THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

Medical Board Registration



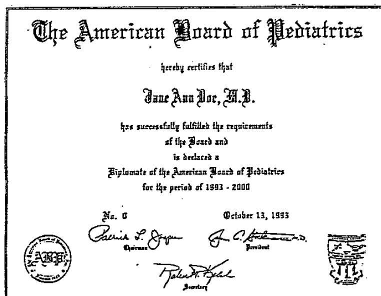
NORTH CAROLINA MEDICAL BOARD

Certificate of Insurance



ACORD CERTIFICATE OF LIABILITY INSURANCE

Board Certification



The American Board of Pediatrics
hereby certifies that
Jane Ann Doe, M.D.
has successfully fulfilled the requirements
of the Board and
is declared a
Diplomate of the American Board of Pediatrics
for the period of 1993 - 2000

No. 0 October 13, 1993

Chairman President

Secretary

A. DEMOGRAPHIC AND PERSONAL DATA:

1. **Name of Applicant:** ____
   Last Name First Name Middle Name Maiden

2. **Date of Birth:** _____/_____/_____ **Place of Birth:** ______________________________

   Social Security Number: _____-_____-______ **Sex: Male** ☐ **Female** ☐

3. **Type of Practice:** **Primary Care** _________ **Specialist**__________

   ______________________________ ______________________________
   (Primary Specialty) (Secondary Specialty)

   Please Identify Areas of Clinical Expertise:______________________________

   ____

   What population(s) do you treat (e.g. geriatric, all ages):______________________________

   ____

   Language(s) Spoken, including sign language: ___________________________Are interpreters available?____________

4. **Name of Practice:** ____

5. **Primary Office Address** (If you maintain more than one office, list each office, address, and hours of operation.)

   Practice Name ____

   ____
   Street City County State Zip

   Handicapped accessible? YES ☐ NO ☐ **Office Phone**: (_____)_____-_____/_____ **Fax** (_____)_____-_____/______
   Accepting New Patients? YES ☐ NO ☐ **Restrictions:** ______________________________
   (Please list or indicate none)

Office Hours

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Secondary Office Address
Name ____

____
Street City County State Zip

Handicapped accessible? YES ☐ NO ☐ **Office Phone:** (_____)_____-_____/_____ **Fax** (_____)_____-_____/_____

Accepting New Patients? YES ☐ NO ☐ **Restrictions:** ______________________________
(Please list or indicate *none*)

Office Hours

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one)_____Billing _____Office

Name ____

____

Street City County State Zip

Handicapped accessible? YES ☐ NO ☐ **Office Phone**: (_____)_____-_____/_____ **Fax** (_____)_____-_____/_____

Accepting New Patients? YES ☐ NO ☐ **Restrictions:** ____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

6. **Name other provider(s) in your practice (if not enough space, please attach additional sheet):**

____ ____

7. **Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice?** **YES** ☐ **NO** ☐
(If yes, please attach proof of professional liability insurance and proof of employment for those individuals)

8. **Name and address of provider(s) who share call with you (if not enough space, please attach additional sheet):**

Name ______________________________________ Name ____

Address ___________________________________Address ____

___________________________________ ____

9. **Arrangements for 24 hour/7 day coverage:**____

10. **Administrative Contact:**____
(Name) (Title) (Telephone)

11. **IRS requires reimbursement be made payable to name of practice affiliated with Federal Tax ID Number:**
Federal Tax ID Number:_____________________
Name (if different from practice name)____
Billing Address (if different from practice address)____
____

12. **UPIN Number**______________________________ **Medicare/Medicaid Number** _______________/_____________

13. **DEA Number** ____ Exp. Date____________________
(Attach copy to application)

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate: ________________________ Expiration Date: __________________
(attach copy to application)

14. **Provide the following information for each state in which you are currently or were previously licensed to practice** (If not enough space please attach additional sheet):

STATE	DATE OF LICENSE	LICENSE NUMBER	STATUS: Active,Inactive,Suspended	EXPIRATION DATE
	/ /			/ /
	/ /			/ /
	/ /			/ /
	/ /			/ /

PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE

15. **Certification of Specialty Boards as applicable:**

a. If you are certified by a specialty board, indicate name of board and date of certificate.

____Date Certified_____/_____/_____ Exp. Date_____/_____/_____
Primary Specialty Board

____Date Certified_____/_____/_____ Exp. Date_____/_____/_____
Secondary Specialty Board

b. Are you listed in the American Board of Medical Specialists? YES ☐ NO ☐

c. If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.
____Date_____/______/______

d. If you have not applied to a specialty board, please explain:____
____
____

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

16. List the dates of all current professional memberships in societies, including state and county societies:

FROM – TO

____–______________

____–______________

____–______________

____–______________

17. List all hospitals where you currently have privileges and indicate the type and status of those privileges:
(Type: active, admitting, associate, consulting, courtesy. Status: pending, provisional, suspended, temporary, visiting)

Hospital	Privilege and Status of Privilege	Estimated % of Admission
________________________________ (primary admitting facility)	________________________________	_____________________
________________________________	________________________________	_____________________
________________________________	________________________________	_____________________
________________________________	________________________________	_____________________

18. If you do not have admitting privileges, who admits for you?

Name ___________________________________ Name ___________________________________

Address _________________________________ Address _________________________________

_________________________________ _________________________________

Phone ___________________________________ Phone ___________________________________

B. EDUCATION AND PRACTICE HISTORY

1. Medical, Dental or other Professional School Attended:

Institution ____

Address ____

____
City State Zip

Degree ____ From ____/____/____ To ____/____/_____

Please attach Educational Commission of Foreign Medical Graduate Certificate - (ECFMG), if applicable.

---

2. Internship:

Institution ____

Address ____

____
City State Zip

Specialty____ From ____/____/____ To ____/____/_____

---

3. Residency:

Institution ____

Address ____

____
City State Zip

Specialty____ From ____/____/____ To ____/____/_____

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4. Other Residency/Fellowship - (specify)

Institution ____

Address ____

____
City State Zip

Specialty____ From ____/____/____ To ____/____/_____

B. EDUCATION AND PRACTICE HISTORY - (Continued)

5. List work history since beginning of medical, dental or other professional school; please be specific.
(If not enough space, please attach additional sheet)

FROM / TO

____ _____ / ___ _____ / ___
Current practice (Month / Year) (Month / Year)

____ _____ / ___ _____ / ___
Previous practice (Month / Year) (Month / Year)

____ _____ / ___ _____ / ___
Previous practice (Month / Year) (Month / Year)

____ _____ / ___ _____ / ___
Previous practice (Month / Year) (Month / Year)

____ _____ / ___ _____ / ___
Previous practice (Month / Year) (Month / Year)

6. List other training and/or education (including CME) within the last three years, if applicable.

____

____

____

____

____

____

7. Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:

____

____

____

8. Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.

____

____

____

C. PROFESSIONAL INFORMATION

Please circle yes or no for the following questions. Please complete the attached Supplemental Form for any questions to which you answer "yes." Also, please sign and date this application. If this application does not have the provider's signature, it cannot be accepted.

	YES	NO
1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? *(If yes, please complete Supplemental Question No. 1.)*	Y	N
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? *(If yes, please complete Supplemental Question No. 2.)*	Y	N
3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? *(If yes, please complete Supplemental Question No. 3.)*	Y	N
4. Have you ever been sanctioned or suspended by Medicare or Medicaid? *(If yes, please complete Supplemental Question No. 4.)*	Y	N
5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? *(If yes, please complete Supplemental Question No. 5.)*	Y	N
6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? *(If yes, please complete Supplemental Question No. 6.)*	Y	N
7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? *(If yes, please complete Supplemental Question No. 7.)*	Y	N
8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? *(If yes, please complete Supplemental Question No. 8.)*	Y	N
9. Have you ever practiced without liability coverage? *(If yes, please complete Supplemental Question No. 9.)*	Y	N
10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? *(If yes, please complete Supplemental Question No. 10.)*	Y	N
11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? *(If yes, please complete Supplemental Question No. 11).*	Y	N

SUPPLEMENTAL FORM

***Provider Name:*____*Provider ID#*___________________**
(If applicable)

1. *License Limited, Reprimanded, etc.*

List State(s) where action took place ______________________ ______________________ ______________________

Date(s) license revoked, suspended, etc. From ____/___/____ To ___/____/____

Please explain:____

____

____

____

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____

2. *Employment/Membership Suspended, Limited, etc.*

List State(s) where action took place ______________________ ______________________ ______________________

List Professional Organization __________________________ ________________________ _______________________

Please explain:____

____

____

____

____

____

3. *Drug Enforcement Agency (DEA) Explanation*

List State(s) where action took place ______________________ ______________________ ______________________

Please explain:____

____

____

____

____

____

SUPPLEMENTAL FORM

***Provider Name:*____*Provider ID#*___________________**
(If applicable)

4. *Medicare/Medicaid Sanction Disciplinary Action(s)*

Disciplined Action(s):____
List State(s):_________ __________ ___________ Date(s) of Action From____/___/____ To ___/____/____
Please explain:____

5. *National Practitioner Data Bank Report(s)*

Please explain the NPDB report *(if you have a copy please attach)*: ______________________________________

6. *Felony or Misdemeanor*

Did you serve a sentence? Y N If YES, circle how many years 1 2 3 4 5 6 other_______
Please explain charge and verdict____

____ List State(s) _______ _______ _______

SUPPLEMENTAL FORM

Provider Name:____Provider ID#____________________
(If applicable)

7. *Named in Professional Liability Judgment, Settlement, etc.*

Please explain, include dates & amounts:
____
____
____
____
____

8. *Canceled, Refused Coverage, etc.*

Please list Insurance Carrier(s) ______________________________ _________________________________

Please explain:____
____
____
____
____
____

9. *Practiced Without Liability Coverage*

Please explain:____
____
____
____
____
____

SUPPLEMENTAL FORM

ProviderName:**____*****ProviderID#*****____________________**
(If applicable)

10. *Medical, Chemical Dependency, or Psychiatric Conditions*

Please explain in detail:____

____

____

____

____

____

11. *Hospital or Clinic Privileges Revoked, Restricted, etc.*

List Hospital(s) _______________________ ___________________________ ____________________________

Date privileges revoked, suspended, etc. From____/___/____ To___/____/____

Please explain:____

____

____

____

____

____

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in ______________________________, I signify my willingness to appear for interview in regard to my application. I authorize ______________________________ to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to ______________________________ materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of ______________________________of all documents that may be material to an evaluation of my professional qualifications and competence.

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. I release from liability all representatives of ______________________________ for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to ______________________________ in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to ______________________________.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, ______________________________, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in ______________________________ , I hereby consent to ______________________________ for inspection of my patient records relating to ______________________________ enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify ______________________________ in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

____

PRINT NAME OF PROVIDER

____

SIGNATURE OF PROVIDER

____

DATE

Please Sign and Complete this Application

Form **W-9**
(Rev. October 2004)
Department of the Treasury
Internal Revenue Service

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 reported on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

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.

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

Social security number

or

Employer identification number

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. person (including a U.S. resident alien).

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 ▶**

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.

U.S. person. 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.

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.*

For federal tax purposes you are considered a person if you are:

- an individual who is a citizen or resident of the United States,
- a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- any estate (other than a foreign estate) or trust. See Regulation section 301.7701-6(a) for additional information.

Foreign person. If you are a foreign person, 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 recipient 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 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 (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include 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, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

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.

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 social security card. 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 social security card 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). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

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 From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" 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.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

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 recipients listed above, 1 through 15.

IF the payment is for . . .	**THEN the payment is exempt for . . .**
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 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 recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[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-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., 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 on-line at *www.socialsecurity.gov/online/ss-5.pdf*. 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 ID Numbers under Related Topics. 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. Writing "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 recipients, see *Exempt From Backup Withholding* 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 single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
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). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal 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.)

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.

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, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism. The authority to disclose information to combat terrorism expired on December 31, 2003. Legislation is pending that would reinstate this authority.

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
FOR THE STATE OF NORTH CAROLINA

This **PARTICIPATING PROVIDER AGREEMENT** is entered into as of the _____ day of __________, 20__ by and between **DAVIS VISION, INC.**, having its principal place of business located at 159 Express Street, Plainview, New York 11803 ("**DAVIS**"), and _________________________________

____
[Insert PROVIDER's full legal entity name]

having its, his or her principal place of business located at ____
____("**PROVIDER**").
[Insert PROVIDER's complete address]

RECITALS

WHEREAS, **DAVIS** has or intends to enter into agreements with health maintenance organizations and other purchasers of health care services ("**Plan**(s)") to provide or arrange for the provision of health care services to persons enrolled as Participants of such Plans (the "**Contracts**"); and

WHEREAS, **DAVIS** and **PROVIDER** desire to enter into a contract whereby **PROVIDER** agrees to provide certain health care services on behalf of **DAVIS** to Participants of Plans under Contract 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

DEFINITIONS

.1 "**Clean Claim**" means a claim for payment for services which contains the following information: (a) a valid authorization number, referencing member, and Participant 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 pended or denied until all information is received from the **PROVIDER** and/or member.

.2 "**Contracts**" means the agreements between **DAVIS** and Plans to provide or arrange for the provision of health care services to persons enrolled as Participants of such Plans.

.3 "**Copayment" or "Deductible**" means those charges for health care services which shall be collected directly by **PROVIDER** from Participant as payment in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Participant's benefit plan.

.4 "**Covered Services"** means 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 ordering and dispensing plan eyeglasses from the central **DAVIS** laboratory.

.5 "**Medically Appropriate"** means services or treatment which a Participant requires as determined by one or more Participating Provider(s), in accordance with accepted professional practices and standards prevailing at the time of treatment and adopted by **DAVIS**.

.6 **"Non-Covered Services"** means those health care services which are not Covered Services.

.7 "**Participant"** means a person who is enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

.8 "**Participating Provider"** means a licensed health facility which, or a licensed health professional who, has entered into an agreement with a Plan or with **DAVIS** to provide Covered Services to Participants.

.9 "**Plans"** means health maintenance organizations and other purchasers of health care services.

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

II

SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Services: PROVIDER** shall provide all Medically Appropriate Covered Services to Participants within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Participant to ensure that it is cost-effective and Medically Appropriate.

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

(a) **PROVIDER** agrees that the frame collection will be shown to all Participants receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Participants.
(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, with reasonable notice, at any other time. **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) Upon reasonable notice, and at any time, **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 full cost of the display and/or frame collection and will be required to reimburse **DAVIS** its fair market value.

.3 **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 Plans; and (2) promptly provide **DAVIS** and Plans with copies of treatment records when requested; and (3) shall keep treatment records confidential.

.4 **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 Participant(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** agrees not to differentiate or discriminate in the treatment of persons covered under the Plans as to the quality of service delivered because of race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status or method of payment; and to promote, observe and protect the rights of Participant(s) covered under the Plans.

.5 **Open Clinical Dialogue**: Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Participants, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** plan designs.

III

COMPENSATION

.1 **Compensation: DAVIS** shall pay **PROVIDER** the compensation amounts communicated to **PROVIDER** by **DAVIS** from time to time, and hereby incorporated by reference, as full compensation for the Covered Services provided by **PROVIDER** to Participants under an applicable Plan pursuant to this Agreement. **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 Health Care Financing Administration, Department of Health and Human Services. 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 Participant.

.2 **Payment of Compensation:** Payment shall be made within thirty (30) days of receipt of a Clean Claim by **DAVIS**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Participant, less any Copayment and Deductible collected or to be collected from the Participant. Following the provision of Covered Services and for all Covered Services rendered by **PROVIDER** to a Participant hereunder, **PROVIDER** shall submit a claim to **DAVIS**, within one hundred and eighty (180) days from the date Covered Services are rendered, or in accordance with applicable North Carolina statute(s). (Such claim may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**). Failure of **PROVIDER** to submit a claim within one hundred and eighty days (180) days following the provision of Covered Services, or in accordance with applicable North Carolina statute(s) will, at **DAVIS'** option, result in nonpayment by payor to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, erroneous claim payments or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement. In instances when **DAVIS** is not the primary payor, **PROVIDER** will submit a claim to **DAVIS** no later than one hundred and eighty (180) days after receipt of payment from the primary payor, or in accordance with applicable North Carolina statute(s).

.3 **Participant Billing/Hold Harmless:** Except as provided in Section III.4 below, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Participants and shall at no time seek compensation from Participants for Covered Services even if **DAVIS**, for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Participant shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Participant's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement, regardless of the reason for termination, shall be construed to be for the benefit of the Participant, and may not be changed without the approval of appropriate regulatory authorities.

.4 **Participant Responsibility: PROVIDER** shall bill and collect all Copayments and Deductibles specifically permitted in a Participant's benefit plan from the Participant. **PROVIDER** shall further bill and collect all charges from a Participant for those non-Covered Services provided to a Participant. To the extent permitted by law, **PROVIDER** shall provide a courtesy discount of twenty percent (20%) off **PROVIDER'**s usual and customary fees to Participants for the purchase of materials not covered by a Plan.

.5 **Plan Hold Harmless Provisions: PROVIDER** agrees that he/she shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan from any obligation to compensate **PROVIDER** for Covered Services.

IV

OBLIGATIONS OF PROVIDER

.1 **Hours: PROVIDER** agrees to be available to provide Covered Services for Medically Appropriate emergency care and shall be accessible twenty- four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year through an answering service or answering machine which provides a pager number. Services not requiring emergency care shall be provided on a timely basis.

.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) are responsible. **PROVIDER** shall report all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this Section IV.2 to **DAVIS** when billing is submitted for payment.

.3 **Malpractice Insurance:** Unless otherwise agreed upon in a writing by and between the parties hereto, **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement, maintain a policy 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 or employees, and **PROVIDER** shall provide proof of such insurance to **DAVIS** if so requested.

.4 **Performance: PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER's** duties hereunder to Participant(s). **PROVIDER** shall use his/her/its best efforts to ensure that health care services provided under this Agreement are of a quality that is consistent with accepted professional practices. **PROVIDER** agrees to abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of health care services.

.5 **Compliance with Law 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, all applicable rules and regulations, and the ethical standards of the appropriate professional society. 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 timely 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. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and federal law, as amended, and all regulations issued pursuant thereto. As may be required by law, **PROVIDER** agrees to maintain such records and provide such information to **DAVIS,** and to contracting Plans, and applicable state and federal regulatory agencies for compliance. **PROVIDER** agrees to retain such books and records for a term of at least six (6) years from and after the provision of Covered Services and in the case of a minor who receives services from **PROVIDER**, for a minimum of six (6) years from the time such minor attains the age of majority. **PROVIDER**'s obligations contained in Section IV.5 herein shall survive termination of this Agreement.

.6 **PROVIDER Roster: PROVIDER** agrees that **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER's** name, address, phone number, type of practice, and willingness to accept new patients in the **DAVIS** or Plan roster of Provider participants. The roster may be inspected by, and is intended to be used by, prospective patients and others.

.7 **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 Davis may, from time to time, amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

.8 **Cooperation with Plan Medical Directors:** **PROVIDER** understands that contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Participants and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Participants. **PROVIDER** agrees to cooperate with contracting Plan medical directors in the medical directors' review of the quality of care administered to Participants.

.9 **Notice of Non-Compliance and Malpractice Actions:** **PROVIDER** shall notify **DAVIS** immediately, in writing, should he/she/it be in violation of any portion of this Article IV. 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.

.10 **Consent to Release Information:** Upon request by DAVIS, **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**.

.11 **Credentialing:** **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**.

.12 **Verification of Eligibility:** **PROVIDER** shall verify eligibility of Participant(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS** or by receiving from Participant(s) a valid pre-certified voucher.

.13 **Office Visits:** **PROVIDER** shall cooperate with all office visits made by **DAVIS**, any external review organization or regulatory agency.

V

TERM OF THE AGREEMENT

.1 **Term:** This Agreement shall become effective on the date first written above and shall thereafter be effective for an initial term of twelve (12) months.

.2 **Renewals**: This Agreement shall be automatically renewed for successive twelve (12) month periods on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

VI

TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause:** After the initial twelve (12) month term, 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 a term hereof, or for a reason other than those set forth in Section VI.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.

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

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

(d) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement;

(e) conviction of a felony;

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

(g) 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 IV.3 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section IV.5 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section IV.7 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section VIII.1 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section IX.12 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 Participant in seeking appropriate Covered Services, or files a complaint or an appeal.

.3 **Responsibility for Participants 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 IV.5 hereof), **PROVIDER** shall continue to provide Covered Services to a Participant who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement until the Covered Services being rendered to the Participant by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a patient), 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 Participant pursuant to this Section VI.3 (prior to and following the effective termination date of this Agreement) at the rates contemplated in this Agreement for Covered Services.

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

.5 **Return of Materials and Payments of Amounts Due:** On 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 at any time during the term of this Agreement.

.6 **Provider Notification to Participants upon Termination:** Should **PROVIDER** terminate this Agreement pursuant to Section VI.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Participant(s) under this Agreement, **PROVIDER** agrees to notify said Participant(s) of the termination prior to its effective date.

VII

DOCUMENTATION AND AMENDMENT

.1 **Documentation:** **DAVIS** shall provide **PROVIDER** with a copy of any document required by a contracting Plan which has been approved by **DAVIS** and which requires **PROVIDER'**s signature. If **PROVIDER** does not execute and return said document within fifteen (15) calendar days of document receipt, **DAVIS** may execute said document as agent of **PROVIDER** and said document shall be deemed to be executed by **PROVIDER**.

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

VIII

UTILIZATION REVIEW, QUALITY MANAGEMENT AND GRIEVANCE PROCEDURES

.1 **Utilization Review and Quality Management Procedures:** 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 Participants. 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 Section VIII.1 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 that 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 Participant which are determined to be not Medically Appropriate or of poor quality or for which **PROVIDER** failed to receive a prior authorization to treat a Participant.

.2 **Grievance Procedure:** A grievance procedure shall be established for the processing of any Participant or **PROVIDER** complaint regarding Covered Services. Such procedure will be established by **DAVIS** and contracting Plans, in their sole and absolute discretion. **PROVIDER** shall comply with and, subject to **PROVIDER'**s rights of appeal, be bound by such grievance procedure.

IX

GENERAL PROVISIONS

.1 **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. 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. Notices shall be delivered or mailed to the addresses appearing in the introductory paragraph on the first page of this Agreement. Either party hereunder may change its address by providing written notice in accordance with this Section IX.1.

.2 **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 signed by the party to be charged.

.3 **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.

.4 **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.

.5 **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 Participant, in the state in which **PROVIDER** rendered services to that Participant.

.6 **Assignment:** This Agreement shall be binding upon, and shall inure to the benefit of the parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** may not assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of **DAVIS**.

.7 **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**.

.8 **Confidentiality:** 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.

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

.10 **Headings:** The subject headings of the articles and sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

.11 **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.

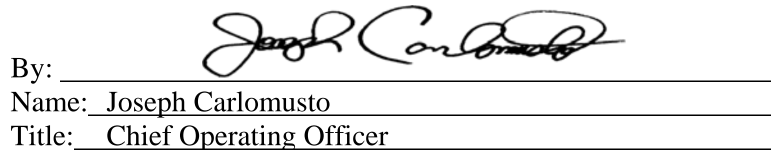
.12 **Non-Solicitation of Participants:** During the term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Participants, Plans or any employer of said Participants 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 Participant or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Participant or an employer of any Participant to disenroll from a Plan contracting with **DAVIS**. A breach of this Section IX.12 shall be grounds for immediate termination of this Agreement.

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

.14 **Proprietary Information:** **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Participant, including but not limited to, the Participant's name, address and telephone number ("Participant 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 Participant/patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Participant 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 Participant if Medically Appropriate for the proper treatment of such Participant or upon the express prior written permission of **DAVIS**, the Plan in which the Participant is enrolled, and the Participant.

IN WITNESS WHEREOF, the parties have executed this Agreement, effective as of the date first written above.

DAVIS VISION, INC.:



By: ______________________________
Name: Joseph Carlomusto
Title: Chief Operating Officer

PROVIDER:

By: ______________________________
(Must be executed by PROVIDER)
Print Name: ______________________________
Print Title: ______________________________

***** Submission of the completed Vision Care Plan Provider Application and/or the 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 the Provider application and on the execution, by Provider, of the Participating Provider Agreement, and the receipt by Provider of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which Provider is acceptable for participation and in which groups a Provider will participate. Following a **PROVIDER's** acceptance by **DAVIS,** should additional practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Participants of Plans under Contract 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.