CREDENTIALING DOCUMENT REQUIREMENTS
FOR NETWORK PARTICIPATION
IN THE STATE OF NEW JERSEY

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**

"New Jersey Universal 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 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, 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.**

New Jersey Universal Physician Application

(Please type or print)

SECTION 1

Personal Information

Physician Name (Last) (First) (MI) (Jr., Sr., etc.)		Professional Degree(s) *(MD, DO, DDS, DMD, DPM, DC)*	Social Security Number
Other Name Used	Years Associated with Former Name	Other Name Used	Years Associated with Former Name
Date of Birth (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female	Are you eligible to work in the United States? ☐ Yes ☐ No	
Home Mailing Address	City	State	Zip Code

Practice Location Information

Type of Service Provided ☐ Primary Care Specialist ☐ Non-Primary Care Specialist			
Physician Group Name/Practice Name *(to appear in the directory)*	Group/Corporate Name *(as it appears on W-9)*, if different from Group Name/Practice Name		
Primary Office Mailing Address	City	State	Zip Code
Primary Office Telephone No.	Primary Office Fax No.	Primary Office E-mail Address	
Tax ID Number and Associated Individual Group Number and Name for This Location			
Are you currently practicing at the above location? ☐ Yes ☐ No	If No, what is your expected start date?		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Correspondence Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	

If you have additional offices, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all States where you are currently or have previously been licensed.)

Type	State(s) of Registration	Do You Currently Practice In This State?	License/Certificate Number	Expiration Date	N/A
License		☐ Yes ☐ No			
License		☐ Yes ☐ No			
DEA Registration Certificate		☐ Yes ☐ No			
CDS Registration Certificate		☐ Yes ☐ No			
Other (CDS/DEA) (Specify)		☐ Yes ☐ No			

UPIN	National Provider ID (when available)	Are you a participating Medicare Provider?	Medicare Provider No.	Are you a participating Medicaid Provider?	Medicaid Provider No.

International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No	If yes, ECFMG Number	ECFMG Issue Date

Medical Education

School Issuing Professional Degree (Medical, Dental, Chiropractic)	Degree	Attendance Dates	
Address	City	State/Country	Zip Code

If you have attended additional schools, please submit an attachment containing the above information and check this box: ☐

Post-Graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	
Post-Graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	
Post-Graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

If you completed additional training, please submit an attachment containing the above information and check this box: ☐

Other Graduate Level Education for Which a Degree Was Obtained - Type of Program (Psychology, Public Health, MBA, etc.)	Institution Name		
Address	City	State	Zip Code
Degree Obtained	Date of Graduation (Month/Year)		

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

Secondary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

Additional Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?

HMO ☐ Yes ☐ No
PPO ☐ Yes ☐ No
POS ☐ Yes ☐ No

If not Board Certified, indicate any of the following that apply:

☐ I have taken exam, results pending for: _____ (board)
☐ I am intending to sit for the Boards on: _____ (date)
☐ I am not planning to take the Boards.

List Additional Areas of Professional Practice, Interest or Focus (HIV/AIDS, etc.)

Hospital Affiliations and Privileges

Do you have hospital privileges? ☐ Yes ☐ No

If you do not admit patients, what admitting arrangements do you have?

If you have privileges, please complete the section below. Include all hospitals where you have privileges.

Primary Hospital where you have Admitting Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Other Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Other Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?
Additional Hospital Where you Have Privileges			Telephone Number
Address	City	State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?

If you have additional hospital affiliations, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

List all other hospitals where you have previously had privileges.			
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code

If you have other previous hospital affiliations, please submit an attachment containing the above information and check this box: ☐

Work History

Include chronological work history since completion of training.			
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code

For additional work history, please submit an attachment containing the above information and check this box: ☐

Please provide an explanation of any gaps greater than six months in each work history.	
Date	Explanation
Date	Explanation
Are you currently on active military duty or on military reserve? ☐ Yes ☐ No	

References

Please provide three professional references that are not partners in your own group practice and are not relatives.	
Name	Street Address City, State, Zip Code

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional Liability Insurance Coverage

Are you self-insured? ☐ Yes ☐ No

Name of Current Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date		Expiration Date
Address		City		State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date		Expiration Date
Address		City		State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier

Status/Role in Practice

☐ Owner ☐ Partner ☐ Employee ☐ Officer ☐ Shareholder

Interests in Outside Clinical Lab(s)

If you own/co-own, or have interests in any other outside clinical lab, please fill in below:

Legal Billing Name	TIN (Attach copy of W-9)	Clinical Description

Please provide a summary pattern for this business:

Office Coverage

List names of colleague(s) providing regular coverage and his/her specialty(ies).

Name	Provider Specialty

Partners

List full names of all partners in your practice (attach list for large group).

Name (Last, First, MI)	Name (Last, First, MI)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

Site 1	Site 2
Office Address:	Office Address:
Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group	Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group
Office Manager or Business Office Staff Contact:: Name: _____ Telephone No.: _____ Fax No.: _____	Office Manager or Business Office Staff Contact:: Name: _____ Telephone No.: _____ Fax No.: _____
Credentialing Contact (if different from above): Name: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____	Credentialing Contact (if different from above): Name: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____
Billing Information: Billing Rep. Name: _____ Address: _____ City: _____ State: _____ Zip: Telephone No.: _____ Fax No.: _____ E-mail: _____ Dept. Name if Hosp.-Based: _____ Check should be payable to _____ Do you have capability of electronic billing? ☐Yes ☐No	Billing Information: Billing Rep. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ Fax No.: _____ E-mail: _____ Dept. Name if Hosp.-Based: _____ Check should be payable to _____ Do you have capability of electronic billing? ☐Yes ☐No

Office Business Hours (hours patients are seen):

Day	No Office Hours	Morning	Afternoon	Evening
MON	☐			
TUES	☐			
WED	☐			
THUR	☐			
FRI	☐			
SAT	☐			
SUN	☐			

Office Business Hours (hours patients are seen):

Day	No Office Hours	Morning	Afternoon	Evening
MON	☐			
TUES	☐			
WED	☐			
THUR	☐			
FRI	☐			
SAT	☐			
SUN	☐			

After hours, back office phone number for health plan business use only:	After hours, back office phone number for health plan business use only:
Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions	Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions

(Continue on next page.)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients?..... ☐Yes ☐No -Existing patients with change of payor?..... ☐Yes ☐No -New patients from physician referral?..... ☐Yes ☐No -New Medicare patients? ..... ☐Yes ☐No -New Medicaid patients?..... ☐Yes ☐No If this information varies by health plan, provide explanation:	Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients?..... ☐Yes ☐No -Existing patients with change of payor?..... ☐Yes ☐No -New patients from physician referral?..... ☐Yes ☐No -New Medicare patients? ..... ☐Yes ☐No -New Medicaid patients?..... ☐Yes ☐No If this information varies by health plan, provide explanation:
Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A _____ List Other Limitations: _____	Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A _____ List Other Limitations: _____
Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, provide the following information for each staff member: Name: _____ Professional Designation: _____ State License Number: Name: _____ Professional Designation: _____ State License Number:	Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, indicate limitations below: Name: _____ Professional Designation: _____ State License Number: Name: _____ Professional Designation: _____ State License Number:
Please attach a list of any additional mid-level practitioners.	*Please attach a list of any additional mid-level practitioners.*
Non-English Languages spoken: by health care professional: _____ by office personnel: _____ Are interpreters available? ☐Yes ☐No If yes, specify languages: _____	Non-English Languages spoken: by health care professional: _____ by office personnel: _____ Are interpreters available? ☐Yes ☐No If yes, specify languages: _____
Does this office meet ADA accessibility standards? ☐Yes ☐No	Does this office meet ADA accessibility standards? ☐Yes ☐No
Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other: _____	Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other: _____
Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other: _____	Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other: _____

(Continue on next page.)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Is this site accessible by public transportation?	Is this site accessible by public transportation?
☐Yes ☐No	☐Yes ☐No
Bus ☐Yes ☐No	Bus ☐Yes ☐No
Subway ☐Yes ☐No	Subway ☐Yes ☐No
Regional Train ☐Yes ☐No	Regional Train ☐Yes ☐No
Other: _____	Other: _____
Does this site provide childcare services? ☐Yes ☐No	Does this site provide childcare services? ☐Yes ☐No
Does this office qualify as a minority business enterprise? ☐Yes ☐No	Does this office qualify as a minority business enterprise? ☐Yes ☐No
Do you or does someone in your office have the following certifications? *(Indicate for each office location.)*	Do you or does someone in your office have the following certifications? *(Indicate for each office location.)*
Yes No Exp.Date	Yes No Exp.Date
BLS (Basic Life Support) ☐ ☐ _____	BLS (Basic Life Support) ☐ ☐ _____
ACLS (Advanced Cardiac Life Support) ☐ ☐ _____	ACLS (Advanced Cardiac Life Support) ☐ ☐ _____
ALSO (Advanced Life Support in OB) ☐ ☐ _____	ALSO (Advanced Life Support in OB) ☐ ☐ _____
PALS (Pediatric Advanced Life Support) ☐ ☐ _____	PALS (Pediatric Advanced Life Support) ☐ ☐ _____
ATLS (Advanced Trauma Life Support) ☐ ☐ _____	ATLS (Advanced Trauma Life Support) ☐ ☐ _____
NALS (Neonatal Advanced Life Support) ☐ ☐ _____	NALS (Neonatal Advanced Life Support) ☐ ☐ _____
CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ _____	CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ _____
Does your site provide any of the following services on site? *(Indicate for each office location.)*	Does your site provide any of the following services on site? *(Indicate for each office location.)*
Laboratory Services ☐Yes ☐No	Laboratory Services ☐Yes ☐No
Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No	Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No
If yes, list program: _____	If yes, list program: _____
Radiology Services ☐Yes ☐No	Radiology Services ☐Yes ☐No
X-Ray Certification ☐Yes ☐No	X-Ray Certification ☐Yes ☐No
If yes, include type: _____	If yes, include type: _____
EKG's ☐Yes ☐No	EKG's ☐Yes ☐No
Care of Minor Lacerations ☐Yes ☐No	Care of Minor Lacerations ☐Yes ☐No
Pulmonary Function Testing ☐Yes ☐No	Pulmonary Function Testing ☐Yes ☐No
Allergy Injections ☐Yes ☐No	Allergy Injections ☐Yes ☐No
Allergy Skin Testing ☐Yes ☐No	Allergy Skin Testing ☐Yes ☐No
Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No	Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No
Drawing Blood ☐Yes ☐No	Drawing Blood ☐Yes ☐No
Age Appropriate Immunizations ☐Yes ☐No	Age Appropriate Immunizations ☐Yes ☐No
Flexible Sigmoidoscopy ☐Yes ☐No	Flexible Sigmoidoscopy ☐Yes ☐No
Tympanometry/Audiometry Screening ☐Yes ☐No	Tympanometry/Audiometry Screening ☐Yes ☐No
Asthma Treatment ☐Yes ☐No	Asthma Treatment ☐Yes ☐No
Osteopathic Manipulation ☐Yes ☐No	Osteopathic Manipulation ☐Yes ☐No
IV Hydration/Treatment ☐Yes ☐No	IV Hydration/Treatment ☐Yes ☐No
Cardiac Stress Tests ☐Yes ☐No	Cardiac Stress Tests ☐Yes ☐No
Physical Therapy ☐Yes ☐No	Physical Therapy ☐Yes ☐No
Additional Office Procedures Provided (incl. surgical procedures)	Additional Office Procedures Provided (incl. surgical procedures)
Is anesthesia administered in your office? ☐Yes ☐No	Is anesthesia administered in your office? ☐Yes ☐No
If Yes, what class or category of anesthesia do you use?	If Yes, what class or category of anesthesia do you use?
_____	_____
Who administers it?	Who administers it?
_____	_____

For additional office sites, please submit an attachment containing the above information and check this box: ☐

Patient Scheduling

What is patient wait time for emergency care? .....
What is patient wait time for urgent care? .....
What is patient wait time for symptomatic care? .....
What is patient wait time for scheduling routine visits? .....
What is patient wait time for scheduling routine care? .....
What is average wait time for patients between waiting room and examination?
What is average wait time in minutes for returning a patient's call? .....

Required Attachments or Supplemental Information

Please attach hard copy or scanned documents of the following:

- Copy(ies) of DEA registration certificate(s)
- Copy of state Controlled Dangerous Substance (CDS) registration certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- Copy(ies) of W-9(s) for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable

SECTION 2 - DISCLOSURE QUESTIONS

Please answer each question and include an explanation for any question answered "Yes."

Licensure

1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? ☐ Yes ☐ No
2. Have you ever received a reprimand or been fined by any state licensing board? ☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ Yes ☐ No
4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ☐ Yes ☐ No
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ Yes ☐ No

Education, Training and Board Certification

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? ☐ Yes ☐ No
7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No
8. Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

DEA or CDS Certification/Authorization

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? ☐ Yes ☐ No

Medicare, Medicaid or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, subject to a recovery action or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No

Other Sanctions or Investigations

12. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? ☐ Yes ☐ No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action? ☐ Yes ☐ No

16. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? ☐ Yes ☐ No

Professional Liability Insurance Information and Claims History

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ Yes ☐ No

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? ☐ Yes ☐ No

Malpractice Claims History

19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case on the attached form located at the end of the Disclosure questions (list all separately). ☐ Yes ☐ No

For any malpractice actions, please complete addendum and check this box: ☐

Criminal/Civil History
(Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all relevant circumstances, including the nature of the crime.)

20. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional? ☐ Yes ☐ No

21. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No

22. Have you ever been court-martialed for actions related to your duties as a medical professional? ☐ Yes ☐ No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Ability to Perform Job

23. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22 It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) ☐ Yes ☐ No

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No

26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? ☐ Yes ☐ No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.

Date of occurrence: _____

Date claim was filed: _____

Claim/case status: _____

_____

Professional liability carrier involved: _____

Address: _____

Telephone Number: _____

Policy Number: _____

Amount of award or settlement and amount paid: _____

Method of resolution: ☐Dismissed ☐Settled (with prejudice) ☐Settled (without prejudice)
☐Judgment for defendant(s) ☐Judgment for plaintiff(s) ☐Mediation or arbitration

Description of allegations: _____

_____

_____

_____

Were you primary defendant or co-defendant? _____

Number of other co-defendants: _____

Your involvement in case (attending, consulting, etc.): _____

Description of alleged injury to the patient: _____

_____

_____

_____

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Please provide information below for any Disclosure Questions in Section II answered "Yes."	
Question No.	Explanation

Provider Initials: _____ Date: _____

SECTION 3 - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with _____ (indicate managed care company(s) to which you are applying) (hereinafter, individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release and Exchange of Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Provider Initials: _____ Date: _____

Releases

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that the information provided on this application may be shared with appropriate State and federal agencies.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further understand and agree that submitting false, misleading or incomplete information may result in the imposition of administrative, civil and/or criminal sanctions, in accordance with State and federal law.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name (Print or Type)	Social Security Number
Signature	Date

Form **W-9**
(Rev. November 2005)
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 shown 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.

In 3 above, 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.

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 Regulations sections 301.7701-6(a) and 7(a) for additional information.

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 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 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 (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,

2. You do not certify your TIN when required (see the Part II instructions on page 4 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 regarding 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). 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 online at *www.socialsecurity.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 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.) Also see *Special rules regarding 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.

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
FOR THE STATE OF NEW JERSEY

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NEW JERSEY** (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.

RECITALS

WHEREAS, **DAVIS** has entered into or intends to enter into agreements (hereinafter "Plan Contract(s)") with health maintenance 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") for the provision of or to arrange for the provision of vision care services 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 such 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 as set forth above are hereby incorporated into and made part of this Agreement.

II
DEFINITIONS

.1 "**Authorization**" means a determination required under a vision care services benefit program that is based upon information provided by the **PROVIDER,** and/or the Member and which satisfies the requirements for Medical Necessity/Medically Necessary Services/Medically Appropriate Services under the Member's vision care services benefit program.

.2 "**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 (HCFA) or any successor agency.

.3 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a valid authorization number, referencing Member and Member 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, if an examination was provided; (f) a description of

services provided (i.e. examination, materials, etc.); and (g) (if applicable) all necessary prescription eyewear order information. Any claim that does not have all of the information as set forth herein may be pended or denied until all information is received from the **PROVIDER**, the Participating Provider and/or the Member. All claims must be received by **DAVIS** within ninety (90) days from the date services were rendered in order for the claims to be adjudicated. If **PROVIDER** is filing a claim under an assignment of benefits from the Member, **PROVIDER** shall file the claim within one hundred eighty (180) days from the last date upon which services were rendered for a particular course of treatment. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax ID number not documented on a properly completed W-9 form are not Clean Claims.

4 "**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.

.5 "**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.

.6 "**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 statutes and/or the regulation(s) of the Commissioner.

.7 "**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.

.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 program, "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, the Member's family or 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**" With respect to Plans other than Medicare 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 the convenience of the Member or the **PROVIDER**; 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 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 are enrolled in or who have entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services. Eligible dependents of Members typically include spouses, minor children, and adult children who are full-time students.

.16 "**New Jersey Department of Banking and Insurance**" (hereinafter "DOBI") means the New Jersey State Division of Insurance which monitors and has regulatory responsibility over health maintenance organizations and insurance producers. ["**Commissioner**" means the Commissioner of the DOBI.]

.17 "**New Jersey Department of Health and Senior Services**" (hereinafter "DHSS") means the division of the New Jersey Department of Human Services (NJDHS) responsible to monitor the quality of care provided within the State by Health Maintenance Organizations (HMO).

.18 "**New Jersey Department of Human Services**, (hereinafter "NJDHS") **Division of Medical Assistance and Health Services**" ("DMAHS") means the division of the NJDHS responsible for the administration of the State Medical Assistance Programs, NJ FamilyCare and NJ KidCare.

.19 **"Non-Covered Services**" means those vision care services which are not Covered Services and which are not covered benefits under the Plan Contracts between **DAVIS** and the Plan(s).

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

.21 "**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.

.22 "**Plans**" means health maintenance organizations, preferred provider organizations, corporations, trust funds, municipalities, employers, employer groups, and/or other purchasers of vision care services that have entered into a Plan Contract with **DAVIS** to have a benefit plan administered by **DAVIS**

.23 "**Plan Contracts**" means the agreements between **DAVIS** and Plans to provide or to arrange for the provision of vision care services to individuals enrolled as Members of such Plans.

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

.25 "**State**" means the State of New Jersey or the state in which the **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders services to a Member.

.26 "**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.

.27 "**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).

.28 "**Utilization Management**" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a vision care service either given or proposed to be given to a Member shall be deemed to be a Covered Service hereunder. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

III
SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **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 Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the Plan frame collection in the exact condition as 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 frames.
(f) Upon reasonable notice, **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection at any time.
(g) Should the display and/or frame 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.

.2 **Open Clinical Dialogue**. Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Members, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** benefit program designs. **PROVIDER** shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.

.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.

.4 **Scope of Practice**. The parties hereto agree and acknowledge that 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 in form and content consistent 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. 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 indicated on Exhibit B. 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 program. **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 that **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 from Members, 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, 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 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. (Such invoicemay be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**.) 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 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.

(a) From time to time, **PROVIDER** may receive Copayments and Deductibles which will afford **PROVIDER** with compensation amounts in excess of the amounts due to **PROVIDER** for providing Covered Services hereunder. Such receipts are hereinafter referred to as a "Negative Balance." When a Negative Balance arises, **DAVIS** shall have the right to offset future compensation owed to **PROVIDER** with the amount owed to **DAVIS**. At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** for a Negative Balance(s). **PROVIDER** shall be responsible to remit such Negative Balance to **DAVIS** within fifteen (15) days of receipt of invoice from **DAVIS**. Should payment not be received by **DAVIS** within the aforementioned timeframe, **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.

.6 **Plan Hold Harmless Provisions**. **PROVIDER** agrees that he/she/it 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; 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 all other sections of 42 C.F.R. § 422 relevant to reporting obligations.

.1.6 Further, **PROVIDER** shall certify the accuracy, completeness and truthfulness of **PROVIDER**-generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to CMS.

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

.3 **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, including but not limited to all applicable rules and regulations and 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. 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, except as provided herein. **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.

.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**. **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 Advantage, or Medicaid Program is found in a policy or other procedural guide of **DAVIS,** Plan(s), NJDHS 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/DMAHS 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 that **DAVIS** is accountable and responsible to the NJDHS and DMAHS, and the NJDHS and DMAHS shall, on an ongoing basis, 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 NJDHS 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 requirements. **PROVIDER** acknowledges that Medicare Advantage Plans are accountable to CMS, that 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 that CMS must oversee Plans' performance. **PROVIDER** acknowledges and understands that 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 and/or its delegates; and that 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** shall be bound by the same standards of confidentiality which apply to the MAP and the State, including unauthorized uses of or disclosures of 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 which is provided due to or 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 his/her/its obligations and securement of his/her/its 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 of information and 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 that, 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**. 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**.

.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 that he/she/it shall be duly licensed by the state in which services are to be rendered, and that he/she/it shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE), and that he/she/it 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 proof of: National Provider Identifier number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees that **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 that at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall immediately notify **DAVIS** in writing in the event that **PROVIDER** suffers a suspension or termination of his/her/its license or of his/her/its professional liability insurance coverage. **PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s). **PROVIDER** shall use his/her/its best efforts to ensure that vision 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 vision care services.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, the DHHS, the MAP, or other appropriate external review organization or regulatory agency ("Oversight Entities") **PROVIDER** shall make available 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 at no cost to **DAVIS** and/or to the requesting Oversight Entity, and in the form and format requested. Further, the **PROVIDER** shall allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours 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 that **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 ninety (90) days notice, or such notice as is reasonably possible, if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/its office location, or (c) reduce capacity at an office location. Under no circumstance shall 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 CMS from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the State or CMS as a result of 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 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 liability to indemnify the State or enrollees of a DMAHS program.

(a) **PROVIDER** shall cause his/her/its employed, affiliated, independent or subcontracted Participating Provider(s) to substantially comply with Section 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)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, need for services, or method of payment; 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 that 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. Further, **PROVIDER** understands that payments for Covered Services hereunder may, in whole or in part, be from Federal funds and that **PROVIDER** is subject to applicable laws related 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"). 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 he/she/it 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 the False Claims Act (31 U.S.C. 3729 et. seq.). **PROVIDER** hereby warrants and represents that **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 that all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier.

(a) **PROVIDER** understands and agrees that 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)/Product 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 that 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 that **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 in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to maintain and 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,** to contracting Plans, to 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, 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, whichever is later.

(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 if **PROVIDER** enters into subcontracts or lease arrangements to render any health/vision care services that are 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 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 Participating 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 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 AND SUSPENSION OF PROVIDER

.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 a term hereof, **PROVIDER** has a right to request a hearing in writing within ten (10) days of receipt of written notice of termination before a panel appointed by **DAVIS**. No such notice or hearing will be given when termination is based on non-renewal of the Agreement, or for reasons as set forth in Section VII.2 hereof.

Such hearing will be held within thirty (30) days of the receipt of the written request. **PROVIDER**'s participation in the aforementioned hearing process shall not be deemed to be an abrogation of **PROVIDER**'s legal rights. Upon **PROVIDER**'s written request, **DAVIS** shall set forth in writing the reasons for termination within fifteen (15) days of receipt of the request, unless the reason for termination has not otherwise been stated in the written notice of termination to **PROVIDER**. **PROVIDER** may not be terminated or penalized solely because of filing a complaint or appeal.

.2 **Termination With Cause**. **DAVIS** may terminate this Agreement immediately for cause. "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) the bankruptcy of **PROVIDER**;

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

(e) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement to include but not be limited to a determination of fraud, breach of contract by **PROVIDER** which represents an imminent danger to a patient or the public health, safety, and welfare in the opinion of **DAVIS**' medical director.

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

.3 **Termination Related to Medicare Advantage**. At the sole discretion of 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 A decision by **DAVIS** and/or Plan(s) to discontinue its/their participation in the

Medicare Advantage Programs; or

.3.2 A decision by **DAVIS** and/or Plan(s) to utilize another network for Medicare Advantage Programs; or

.3.3 A decision by 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 Section VII.4 (prior to and following the effective termination date of this Agreement) at the compensation rates for Covered Services attached to 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 that **PROVIDER**'s obligations as set forth in this Section VII survive such termination.

.5 **PROVIDER Rights Upon Termination**. Upon **PROVIDER**'s request, **DAVIS** shall provide in writing the reason(s) for the termination within fifteen (15) days of the request, if such reason is not otherwise stated in the written notice of 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 Section VII shall be final. The panel shall render a decision on the matter within thirty (30) days of the close of the hearing.

(a) **PROVIDER** acknowledges that Plan(s), the DHS and the DMAHS, 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 **Suspension of Provider**. **DAVIS** may immediately suspend continued participation of **PROVIDER** for cause. **PROVIDER** shall have ninety (90) days from the date of suspension to cure the reason(s) for suspension. Should **PROVIDER** not cure, the suspension will revert to a termination effective on the ninety-first (91st) day from the date of suspension. "Cause", for the purposes of this section shall mean:

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

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

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

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

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.9 hereof.

.7 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. 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** retains the right to reclaim the frame selection 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.

.8 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate the subject Agreement pursuant to Section VII.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Members under this Agreement, it agrees to notify said Members of this action prior to the effective date of said termination.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS** on thirty (30) days advance written notice to **PROVIDER**. If **PROVIDER** does not agree with the amendment, **PROVIDER** may so indicate, in writing, within ten (10) business days of receipt of the amendment. **DAVIS** shall have the right to review such notice and may offer an alternative. If a compromise cannot be reached by the parties, either **DAVIS** or **PROVIDER** shall have the right to terminate this agreement upon thirty (30) days written notice.

.2 **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**.

.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.

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.

.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 Section IX.3 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 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**. The grievance procedure, as set forth herein as Exhibit A shall be followed for the processing of any patient or **PROVIDER** complaint regarding Covered Services. Such procedure may be amended from time to time, either by **DAVIS** or contracting Plans, subject to the provisions set forth in Section VIII.1.

.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; 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 **Alternative Dispute Resolution**. Any controversy or claim arising out of or relating to this Agreement or the breach thereof may be voluntarily settled by alternative dispute resolution.. Such arbitration shall occur within the State of New Jersey, unless the parties mutually agree to have such proceedings in some other locale. **PROVIDER**'s participation in an arbitration hearing shall not be deemed

to be an abrogation of **PROVIDER**'s legal rights, unless otherwise agreed at the time of dispute. This alternative dispute resolution process shall be governed by N.J.A.C. 11:22-1.8(b), as may be amended, which sets forth the following:

(a) The alternative dispute resolution mechanism shall be through an independent party.
(b) The costs of the process shall be borne equally by the parties.
(c) The recommended decision of the alternative dispute resolution mechanism shall be issued no later than thirty (30) business days from receipt by the ADR firm of all documentation necessary to complete the review.
(d) The alternative dispute resolution mechanism, including the method to submit a claim through such mechanism, shall be as set forth herein in Exhibit A.
(e) The decision of the alternative dispute resolution mechanism shall be non-binding unless the parties agree otherwise.
(f) **DAVIS** shall annually notify **PROVIDER** in writing of the internal appeals process and the alternative dispute resolution mechanism and how they can be utilized.

.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 state or federal law is hereby amended to conform with 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 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 Section X.9 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. 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 herein. 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-

IN WITNESS WHEREOF, the parties 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 the completed NJ Universal Physician Application and/or the Participating Provider Agreement for the State of New Jersey does not constitute acceptance as a Davis Vision Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by Davis Vision of the practitioner's completed NJ Universal Physician Application and on the execution by the practitioner of the Participating Provider Agreement for the State of New Jersey, and on the receipt by practitioner of the forms, manual and samples required for network participation. Davis Vision reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a Provider's acceptance by Davis Vision, should additional practitioner(s) join Provider's practice and provide Covered Services to the Members(s) of Plans under Plan Contract with Davis Vision, such additional licensed and credentialed 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 the Agreement.

DAVIS VISION, INC.:

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

Effective Date: _____
[For DAVIS use ONLY]

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

EXHIBIT A

GRIEVANCE PROCEDURE

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PROVIDER APPEALS PROCEDURE – PAYMENT OF CLAIMS

To appeal a claims decision, a practitioner must notify Davis Vision in writing of their intention to seek modification or reversal. The practitioner must send a written request for an internal review to modify or reverse a decision to terminate to the address listed on the notice of action. The request must be sent by certified mail, return receipt requested and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner. There is no fee associated with a request for an internal review.

Davis Vision shall conduct an internal review by employees of Davis Vision who are not responsible for claims payment on a day-to-day basis. Notice of the decision of this internal review will be communicated in writing to the practitioner with ten (10) business days of the receipt of the appeal.

Such written decision shall include, but not be limited to the following information: (i) the names, titles, and qualifying credentials of the persons participating in the internal review; (ii) a statement of the participating providers grievance; (iii) the decision of the reviewers, along with a detailed explanation of the contractual and/or medical basis for such decision; (iv) a description of the evidence or documentation which supports the decision; and (v) if the decision is adverse, a description of the method to obtain an external review of the decision.

EXTERNAL REVIEW – PAYMENT OF CLAIMS APPEALS

Should a practitioner wish to further appeal a claims decision, the parties agree that any dispute between the parties shall be resolved exclusively at the American Arbitration Association in accordance with the rules of said Association.

The cost of such arbitration shall be borne equally between Davis Vision and the practitioner. The parties agree that the recommended decision of the arbitrator(s) shall be rendered within thirty (30) business days from the receipt of the all documentation necessary to complete the review.

The parties agree that the decision of the arbitrator(s) shall be non-binding unless the parties agree otherwise.

PROVIDER APPEALS PROCEDURE - TERMINATION

To challenge a termination decision, a practitioner must notify Davis Vision in writing of their intention to seek modification or reversal. The practitioner must send a written request for a hearing to modify or reverse a decision to terminate to the address listed on the notice of action. The request must be sent by certified mail, return receipt requested and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner.

Within thirty (30) days of receipt of a request for a hearing to modify or reverse the decision to terminate, a three-member Appeals Committee composed of at least one Regional Quality Assurance Representative, all of whom are licensed optometrists, not involved in the initial determination shall convene to review the merits and circumstances presented. Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

If the practitioner requires additional time or wishes to reschedule the hearing, the request for additional time or to reschedule must be made in writing, sent by certified mail (return receipt requested), and be received at Davis Vision at least ten (10) days before the scheduled hearing before the Appeal Committee.

Any documentation to be submitted by the practitioner at the hearing before the Appeals Committee, including the names, addresses and credentials of any witnesses, if applicable, must be mailed to the address listed in the notice of action by certified mail, return receipt requested and be received at least ten (10) days before the scheduled hearing date. The Appeals Committee at its discretion may accept documentation or testimony of witnesses received after this date.

At the hearing, the practitioner will present his/her explanation as to why the decision for termination should be modified or reversed. The Director of Professional Services or Vice President of Professional Affairs will present Davis Vision's position regarding the termination.

The Appeals Committee will prepare a report containing its findings and recommendation with respect to the appeal and forward the report to the overall Quality Support, within thirty (30) days of the hearing. The overall Quality Support, then considers the Appeals Committee's findings and recommendations and either accepts or rejects them within fifteen (15) days. If the findings and recommendations are accepted, the overall Quality Support will advise the practitioner in writing of the decision to accept the Appeals Committee's report as submitted, a copy of which will be enclosed. If the overall Quality Support rejects any of the Appeals Committee's findings or its recommendations, the overall Quality Support will issue a decision stating the reasons for rejecting the particular finding or the recommendation, a copy of which will be sent to the practitioner. Where the decision of the overall Quality Support results in the termination of a practitioner, Davis Vision will notify the practitioner in writing of his or her effective termination date. The termination date is effective upon the practitioner's receipt of the notice. The decision of the overall Quality Support constitutes Davis Vision's final decision with respect to the practitioner's network participation status.

If the decision of the overall Quality Support results in the termination of a practitioner's participation in accordance with the above policy, Davis Vision will notify, when appropriate, the National Practitioner Data Bank (NPDB) and the appropriate state licensing board(s) of its actions.

EXHIBIT B

COMPENSATION

PROFESSIONAL FEES*

*Fees listed below are sample fees for illustrative purposes only and do not reflect fees for all plans. All plan fees are considered reimbursement in full, whether fees are reimbursed entirely by Davis Vision or reimbursed in part by Davis Vision and in part by Member Co-payment.

Eye Examination** Ranges from $40.00 - $52.00
(**Including dilated fundus examination)

Eyeglass Frame Dispensing Fee+ Ranges from $15.00 - $30.00
(+Frames are supplied from the Davis Vision Tower Collection. Frames supplied by a Provider are sent to a Davis Vision laboratory for lenses.)

Contact Lens Fitting Fee^ (*when covered as an itemized service)* Ranges from $20.00 - $85.00
(^When contact lenses are supplied by Davis Vision – i.e. plan contact lenses are daily wear soft & disposable/planned replacement. Non-plan contact lenses are supplied by the Provider's usual source.)

DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT

ADDENDUM
FOR CONTRACTS COVERING
INDIVIDUALS WHO ARE MEMBERS OF HEALTH MAINTENANCE ORGANIZATIONS
IN NEW JERSEY

The Participating Provider Agreement (the "Agreement") entered into by and between **DAVIS** and **PROVIDER** is hereby amended with respect to individuals who are Members of health maintenance organizations (collectively, "**HMOs**") in the State of New Jersey by adding the following

1. Incorporation by Reference. The contract(s) between **DAVIS** and the **HMO(s)** is/are incorporated into the Agreement as more fully set forth herein. **PROVIDER** may obtain a copy of such contract(s) from **DAVIS** upon request.

2. Periodic Accounting. When any compensation formula provides any payment to Provider which may be contingent on the occurrence of particular events or on the meeting of specified utilization targets, **PROVIDER** shall be entitled to receive an annual report with respect to such contingencies and the compensation derived therefrom. Such compensation formula, if any, is intended solely to encourage the cost effective delivery of Medically Appropriate Covered Services and not to provide a financial incentive to **PROVIDER** to deny Medically Appropriate Covered Services. Any dispute regarding such periodic accounting shall be resolved in accordance with Section X.1 of the Agreement.

3. Grievance and Appeal Procedure. A grievance and appeal procedure shall be established for the processing of any patient or provider complaint. Such procedure will be established by **DAVIS** and contracting Plans in their sole and absolute discretion. **PROVIDER** shall cooperate with and, subject to **PROVIDER'**s rights of appeal thereunder, shall be bound by such grievance procedure.

4. Responsibility for Members at Termination. In the event the Agreement is terminated for any reason except the failure to comply with legal requirements or the loss of licensure (as set forth in Section V of the Agreement), where medically necessary for the Member to continue treatment with **PROVIDER**, **PROVIDER** shall be continue to provide Covered Services as provided in Section VII.4 of the Agreement for up to one hundred twenty (120) days after such termination of the Agreement.

5. Malpractice Insurance. Except as may otherwise be required or permitted by the laws of the state in which services are provided, **PROVIDER** shall provide, at **PROVIDER**'s sole cost and expense, throughout the entire term of this Agreement, a policy of professional malpractice liability 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 shall provide proof of such insurance to **DAVIS** if so requested.

6. Termination Without Cause. After the first twelve (12) months, the Agreement may be terminated without cause by either party on ninety (90) days' prior written notice. If **DAVIS** elects to terminate the Agreement other than at the end of the term hereof, or for a reason other than those set forth in Section VII.2 and VII.3 hereof, the notice of termination shall inform the **PROVIDER** that the **PROVIDER** may appeal the termination by requesting a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of the request.

7. Coordination of Benefits Obligation of Davis. **DAVIS** will conduct COB in accordance with the laws of New Jersey.

8. Independent Contractor. It is the intent of the parties that at all times relevant to and pursuant to the terms and conditions of this Agreement, as permitted by statute, regulation and common law, **PROVIDER** is and shall be an independent contractor practicing **PROVIDER'S** profession and shall not be deemed or construed to be an agent, servant or employee of **DAVIS**.

Except as otherwise provided in this Addendum, all capitalized terms shall have the meanings set forth in the Agreement.

DAVIS VISION, INC.
NEW JERSEY PARTICPATING PROVIDER AGREEMENT
MEDICAID ADDENDUM

PROVIDER acknowledges and agrees that **PROVIDER** and/or Participating Providers are bound by the terms of this Medicaid Addendum only to the extent applicable to the services rendered by **PROVIDER** and/or Participating Providers to the enrollees of the State Medical Assistance Programs, NJ FamilyCare and NJ KidCare, and any successor Programs**.**

For the purposes of this Medicaid Addendum the following are defined terms. Those terms not defined below, but previously defined in this Agreement retain the meaning given them in the Agreement.

1. "Contractor" means the Managed Care Organization (MCO)
2. "Contract/Subcontract" means this Davis Vision Participating Provider Agreement for the State of New Jersey.
3. "Provider/Subcontractor" means the **PROVIDER** as defined in this Agreement and the Participating Provider as defined in this Agreement.
4. For purposes of this Medicaid Addendum, the "New Jersey Department of Human Services" (NJDHS) is also referred to as the "Department".

The **PROVIDER** agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the contractor**.**

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontract agrees that it shall carry out its obligations as herein provided in a manger prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the contractor's agreement with the State

takes effect.

E.NON-RENEWAL/TERMINATIN OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the contractor's network. If the termination was "for cause," the contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in this section F.1 shall be construed:

a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between provider/subcontractors and their patients; or
b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontract or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT BY CONTRACTOR

The contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the contractor's decision; or because the provider/subcontractor discusses

with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the contractor or not, policy provisions of the contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;
2. Takes any action that threatens the fiscal integrity of the Medicaid program
3. Has is certification suspended or revoked by DOBI, DHSS, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;
5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;
6. Materially breaches the provider contract/subcontract; or
7. Violates state or federal law.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.
2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C. §12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation

in programs or activities provided by a public entity.

The provider/subcontractor shall submit to MCO a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental history, health or mental status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.
4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq.. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on the grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, martial status, genetic information, source of payment, sex, color, creed, religion, or national original or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, martial status, religion, disability or sexual or affectional orientation or preference.
5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring ,employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.
6. Grievances. The provider/subcontractor agrees to forward to MCO copies of all grievances alleging discrimination against enrollees because of race color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap, for review and appropriate action within three (3) business days or receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.
2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the contractor or the state, insolvency of the contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than

provided in section 2.P.

3. The providers/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the contractor, and shall be construed to be for the benefit of the contractor or enrollees.
4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereinafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.
5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.
6. The provider/subcontractor shall comply with the prohibition against balance billing as described within the payment in-full provision of N.J.S.A. 30:4D-6(c).

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontract shall furnish any such record, or copy therof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to

enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or
2. three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directred by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.
2. The provider/subcontractor shall comply with the financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare Plan D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and

employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents and employees arising out of the alleged violation of any State or federal laow or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Acces to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollees's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor; it; (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all request for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and

shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD AND ABUSE

1. The provide/subcontractor agrees to assist the contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.
2. If the State has withheld payment and or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to withhold payments from the provider/subcontractor

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.
2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the contractor.
3. In the following situations, the provider/subcontractor may bill the contractor first and then coordinate with the liable third party, unless the contractor has received prior approval from the State to take other action.
   (a) The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
   (b) The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
   (c) The claims is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.
   (d) The claim is for a child who is in a DYFS supported out of home placement.
   (e) The claims involves coverage or services mentioned in 3.a, 3.b, 3.c., or 3.d, above in combination with another service.
4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the contractor without having received a written denial from the third party.

5. Sharing of Third Party Liability (TPL) Information by the Provider/Subcontractor.
    a. The provider/subcontractor shall notify the contractor within the thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollees' health insurance coverage.
    b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollees' diagnosis and the nature of the service provided to the enrollee.
    c. The provider/subcontractor shall notify the contractor within thirty (30) days of the date it becomes aware of the death of one of its Medicaid enrollees age 55 or older, giving the enrollee's full name, Social Security Number, Medicaid information number, and date of death.
    d. The provider/subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

COST SHARING REQUIREMENTS FOR NJ FAMILYCARE
PLAN C BENEFICIARIES

PERSONAL CONTRIBUTION TO CARE (PCC) FOR NJ FamilyCare – PLAN C

For beneficiaries solely eligible through NJ FamilyCare-Plan C, PCCs will be required for certain services provided to individuals whose family income is above !50% and up to and including 200% of the federal poverty level. Exception – Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, shall not be required to pay a personal contribution to care.

The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring PCCs and the amount of each PCC.

SERVICE	**AMOUNT OF PCC**
Optometrist Services	$5 PCC for each visit.
Physician Services	$5 PCC for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment age appropriate immunizations; prenatal care; and pap smears, when appropriate.

COST SHARING REQUIREMETNS FOR NJ FAMILYCARE
PLAN D BENEFICIARIES

COPAYMENTS FOR NJ FamilyCare – PLAN D

Copayments will be required of parents/caretakers solely eligible through NJ FamilyCare Plan D whose family income is between 151% and up to including 200% of the federal poverty level. The same copayments will be required of children solely eligible through NJ FamilyCare Plan D whose family income is between 201% and up to and including 350% of the federal poverty level. Exception – Both Eskimos and Native American Indians under the age of 19 are not required to pay copayments.

The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring copayments and the amount of each copayment.

SERVICE	**AMOUNT OF COPAYMENT**
Optometrist Services	$5 copayment for each visit, except for newborns covered under fee-for-service.
Physician specialist office visits during normal office hours	$5 copayment per visit.
Physician specialist office visits during non-office hours or home visits	$10 copayment per visit.

COST SHARING REQUIREMENTS FOR NJ FAMILYCARE PLAN H BENEFICIARIES

Copayments will be required of individuals eligible through NJ FamilyCare Plan H whose family income is between 151% and up to and including 250% of the federal poverty level. The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring copayments and the amount of each copayment.

SERVICE	**AMOUNT OF COPAYMENT**
Physician specialist office visits during normal office hours	$5 copayment per visit.
Physician specialist office visits during non-office hours or home visits	$10 copayment per visit.