CREDENTIALING DOCUMENT REQUIREMENTS
FOR NETWORK PARTICIPATION IN OHIO

Davis Vision's provider credentialing policy for network participation requires all applicants/practitioners to **complete and/or provide all information and 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.

_____ **APPLICATION**

"Ohio Department of Insurance Standardized Credentialing Form"

_____ **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF OHIO^**

^All applicants/practitioners must **sign and complete all information required on the signature page of the Participating Provider Agreement for the State of Ohio. A complete and signed original Agreement must be forwarded to Davis Vision** along with a completed and signed Provider Application.

_____ **W-9 FORM**

_____ **COPY OF BLANK PATIENT EXAM FORM**

_____**NATIONAL PROVIDER IDENTIFIER (NPI) Number**
(Please enter NPI # above.)

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

Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please complete each section thoroughly.
Attach additional sheets where necessary.
Type or print clearly in black ink.
Sign and date the application.

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION
(use this checklist as a guide)

- ☐ Copy of State License(s)
- ☐ Copy of DEA Registration
- ☐ Copy of State Controlled Dangerous Substance Certificate
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- ☐ Copy of Board Certification Certificate, if applicable
- ☐ Copy of certificate or letter certifying formal post-graduate training
- ☐ Copy of Curricula Vita/Resume
  Include work history. (**Not accepted as a substitute for completion of application.**)
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used
- ☐ Copy of certificates for conducting x-ray and/or laboratory services (if applicable)
- ☐ Copy of Workers Compensation Certificate of Coverage (if applicable)
- ☐ Copy of certificates of Advanced Nurse Practitioners employed by the office (if applicable)
- ☐ Other _____

Provider's Name _____ Date _____

Health Insuring Corporation's Name _____

Note: Submit this form directly to licensed health insuring corporations and other entities that credential providers for participation in their networks. Do not send this form to the Ohio Department of Insurance; the Department does not use the form for any reporting purposes.

Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please type or print
Fill in all sections - incomplete applications will not be processed.

To be completed by MDs, DOs, DDSs, DPMs, and DCs, and other health care providers.

Date _____

SECTION I
PERSONAL INFORMATION

Name (Last, First, Middle) _____ Degree _____

Home Address/Street _____

City/State/Zip _____

Home Phone Number _____ Cellular Phone Number _____

Date of Birth (for Data Bank Query) _____ Sex: ☐ Male ☐ Female

Place of Birth: (City, State & Country) _____

Languages Spoken _____

Citizenship _____

If not an American citizen, Status & Visa Number _____

SSN # _____

Beeper # _____ Digital: ☐ Yes ☐ No Answering Service # _____

SECTION II
LICENSURE/CERTIFICATIONS/REGISTRATIONS

For all the questions in this section, if you do not have a number but have applied, please indicate "application in process."

Ohio License Number _____ Expiration Date _____

Other State License Number/State of License (list all past and current)

_____ Expiration Date _____

_____ Expiration Date _____

_____ Expiration Date _____

Federal DEA Number _____ Expiration Date _____

Date Issued _____

State Narcotics Registration # or CDS Certification/State of Registration (if applicable) _____ Expiration Date _____

CPR Certifications:

Are you certified in CPR?	☐	Yes (attach copy of certificate(s))	☐	No	Expiration Date _____
Check classification(s):	☐	Basic Life Support (BLS)	☐	No	Expiration Date _____
	☐	Advanced Cardiac Life Support (ACLS)	☐	No	Expiration Date _____
	☐	Health Care Provider (Core C)	☐	No	Expiration Date _____
	☐	Advanced Trauma Life Support (ATLS)	☐	No	Expiration Date _____
	☐	Neonatal Resuscitation Program (NRP)	☐	No	Expiration Date _____
	☐	Pediatric Advanced Life Support (PALS)	☐	No	Expiration Date _____
	☐	Pediatric Emergency Medicine Course (APLS)	☐	No	Expiration Date _____

Other professional certifications or credentials (please include description) _____

_____

Optometrists Only:

Therapeutics Classification Number _____

SECTION III
OFFICE/PRACTICE INFORMATION

Please include all offices/practices. **Copy and complete this sheet for <u>each</u> additional office.**

Is this your primary office? ☐ Yes ☐ No

What type of care do you provide? ☐ Primary Care ☐ Specialty Care

Specialty: _____ Subspecialty: _____

Type of Practice: ☐ Solo ☐ Single Specialty Group ☐ Multi-specialty Group/Other ☐ Hospital Based

Please list other members of your practice and their specialties. _____

_____

Please list the coverage arrangements for your office.

_____

Start date with practice: _____

If you have more than one office please indicate the preferred mailing address

Office Address/Street _____

City/State/Zip _____ County _____

Office Phone _____ After-hours number _____

Office Fax _____ Office e-mail address _____

Ohio Medicare PIN (Provider Identification Number) _____

Ohio Medicaid Provider Number _____

National Provider Identification Number (formerly UPIN) _____

BWC Provider Number _____

Workers' Compensation Employer Risk Number _____

CLIA Certificate ☐ Yes ☐ No

Staff Person responsible for credentialing _____

Phone _____ Fax _____ E-mail _____

Office Manager _____

Phone _____ Fax _____ E-mail _____

Do you use a billing service? ☐ Yes ☐ No

If Yes, list the name and contact information: _____

Does your billing service bill electronically? ☐ Yes ☐ No

Group or Corporate name (as it appears on W-9) _____ Federal Tax ID # _____

Who should check be payable to? _____ Billing Phone _____

Billing Address/Street (if different from above) _____

City/State/Zip _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Indicate the hours that the doctor(s) is/are available:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Languages spoken by office personnel (other than English) _____

Based on your individual practice, do you currently: (check appropriate box for each item)

Accept new patients into your practice?	☐ Yes	☐ No	Accept new Medicare patients?	☐ Yes	☐ No
Accept new patients from phys. referral only?	☐ Yes	☐ No	Accept new Medicaid patients?	☐ Yes	☐ No
Provide inpatient care?	☐ Yes	☐ No	Accept new BWC patients?	☐ Yes	☐ No
Have any age restrictions?	☐ Yes	☐ No			

If YES, what are they? _____

Does the office: (check appropriate box for each item)

Make 24-hour phone coverage available?	☐ Yes	☐ No	Provide childcare services?	☐ Yes	☐ No
Have capability for electronic billing?	☐ Yes	☐ No	Meet ADA accessibility standards?	☐ Yes	☐ No
Have internet access?	☐ Yes	☐ No	Communicate with health plans via the Internet?	☐ Yes	☐ No
Offer patients internet access to obtain medical, billing, and appointment information?	☐ Yes	☐ No	Have public transportation access?	☐ Yes	☐ No
Have other services for the disabled? (TTY, American Sign Language, mental/physical impairments, etc.)	☐ Yes	☐ No	Employ or contract with allied health professionals including physician assistants and Advanced Nurse Practitioners?	☐ Yes	☐ No

Please list services

_____

_____

_____

_____

If Yes, please list all names

_____

_____

_____

_____

SECTION IV
PROFESSIONAL / MEDICAL EDUCATION & TRAINING/WORK HISTORY

Provide history (since medical school) of ***all*** work, education and training including but not limited to medical military services, public health or business training. Provide an explanation for any gaps of more than two months.

MEDICAL EDUCATION

University _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Degree _____ Month/Year Started _____ Month/Year Completed _____

University _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Degree _____ Month/Year Started _____ Month/Year Completed _____

INTERNSHIP

Facility _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Type _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

RESIDENCIES

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

FELLOWSHIPS

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number: _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Other Graduate Level Education for which a degree was obtained

Degree(s) obtained _____

Institution _____

Address/Street _____

City/State/Zip _____

Telephone Number _____

Dates (from/to) _____

Program Director _____

International Medical Graduates

Are you certified by the Educational Council for Foreign Medical Graduates? ☐ Yes ☐ No

ECFMG # _____

Date Issued _____

ADDITIONAL QUALIFICATIONS/TRAINING

List below in chronological order, any and all additional training and places of practice, including medical military services, subspecialty training programs, or public health or business training. If more space is needed, please include an attachment. Include the following information: Dates of the training (from/to), program/training name, location (address), telephone number, contact person, and relevant comments

WORK HISTORY

Practice/Employer _____

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

Practice/Employer _____

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

Practice/Employer _____

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

SECTION V
PROFESSIONAL / MEDICAL SPECIALTY INFORMATION

For each specialty below, please indicate if you are qualified or board certified:

PRIMARY SPECIALTY _____ ☐ Qualified ☐ Certified ☐ Not certified ☐ No board available

Certifying Board _____ Date _____

Is certification current? ☐ Yes ☐ No

Dates of current certification From (month/year) _____ To (month/year) _____

Have you been recertified? ☐ Yes ☐ No Date _____

If status is qualified, give date status expires. Date _____

If qualified, date exam scheduled. Date _____

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

SECONDARY SPECIALTY (Secondary area of practice) _____ ☐ Qualified ☐ Certified ☐ Not certified ☐ No board available

Certifying Board _____ Date of initial certification _____

Is certification current? ☐ Yes ☐ No

Dates of current certification From (month/year) _____ To (month/year) _____

Have you been recertified? ☐ Yes ☐ No Date _____

If status is qualified, give date status expires. Date _____

If qualified, date exam scheduled. Date _____

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

If you have applied to a specialty board for examination, give the name of the board and the date of application.

Board _____ Date _____

Board _____ Date _____

Board _____ Date _____

**Note: Submit copies of all certificates with application including copies of letters attesting to board eligibility.*

PROFESSIONAL AFFILIATIONS (e.g. AMA, AOA) _____

SECTION VI
HEALTH CARE AFFILIATIONS

List all health care facilities at which you have privileges. (Copy this page for additional facilities.)

Status of Privileges Key				
1 Active	4 Associate	7 Courtesy	10 Provisional	13 Pending
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Suspended	14 Other
3 Active Provisional Staff	6 Temporary	9 Senior Staff	12 Consulting	

PRIMARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary*.)

SECONDARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary*.)

SECONDARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary*.)

OTHER FACILITIES

List all other health care facilities or practices where you have had privileges and indicate whether your privileges were restricted in any way at any of the facilities. (*Attach additional pages if necessary*)

OTHER FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

_____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary*.)

_____

SECTION VII
PROFESSIONAL REFERENCES

List three (3) professional/medical references from individuals who have worked extensively with you or who have been responsible for professional observation of your work within the past three years. Only one reference can be a current partner or associate. Do not include relatives.

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

SECTION VIII
PROFESSIONAL LIABILITY INSURANCE COVERAGE

Provide professional liability insurance coverage information for the previous ten (10) years.

☐ Not Applicable Reason _____

MALPRACTICE CARRIER

Carrier Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Policy number _____

Length of time with this carrier _____

If coverage with this carrier is less than ten (10) years, please list your previous carrier(s). (Attach additional pages if necessary)

Amount of coverage
(Per claim/Aggregate) _____

Type of coverage ☐ Occurrence ☐ Claims made

Effective dates (from/to) _____

Renewal date _____

Agent Name _____

Address/Street _____

City/State/Zip _____

PREVIOUS CARRIER

Carrier Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Policy number _____

Amount of coverage
(Per claim/Aggregate) _____

Type of coverage ☐ Occurrence ☐ Claims made

Effective dates (from/to) _____

Agent Name _____

Address/Street _____

City/State/Zip _____

SECTION IX
MALPRACTICE CLAIMS HISTORY

Provide information for all cases occurring in previous ten (10) years. Attach additional sheets if necessary. This sheet may be photocopied. ☐ No claims to date

Date of occurrence _____ Date claim was filed with malpractice carrier _____

Professional liability carrier involved _____

Address (if different from Section VII _____

Patient name _____ Age _____ Sex _____

Name of Plaintiff, if other than patient _____

You were (Check one): ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _____

Describe the allegations against you _____

_____

_____

Describe the alleged injury to the patient _____

_____

Claimant/Plaintiff filed suit in court ☐ Yes ☐ No If yes, date filed _____

State Court Case Number _____ State _____ County/Parish _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the Claim/Case (Include amount awarded/attributed/settlement)

☐ Pending ☐ Settled ☐ Arbitrated ☐ Award

☐ In Appeal ☐ Adjudicated ☐ Withdrawn Date _____

Other, please specify _____

If pending, amount being sought $ _____

Amount of award or settlement $ _____

Amount paid on your behalf $ _____

Amount paid by all parties $ _____

Additional information/explanation (*e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered, and the condition of the patient subsequent to treatment*)

_____

SECTION X
DISCLOSURE INFORMATION

Please answer the following questions "yes" or "no". If your answer to questions 1-18 is "yes" or if your answer to question 19 is "no", please provide a written explanation on a separate sheet.

INSTRUCTION NOTE: A voluntary surrender or non-renewal is for reasons related to professional competence or conduct when the surrender or non-renewal is done to avoid an adverse action, preclude an investigation or is done while the licensee is under investigation related to professional competence or conduct.

1.	Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify?	☐ Yes	☐ No
2.	Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending?	☐ Yes	☐ No
3.	Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending?	☐ Yes	☐ No
4.	Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending?	☐ Yes	☐ No
5.	Have you ever been placed on probation or asked to resign an internship or residency training program?	☐ Yes	☐ No
6.	Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct?	☐ Yes	☐ No
7.	Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program?	☐ Yes	☐ No
8.	Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)?	☐ Yes	☐ No
9.	Have you ever been named as a defendant in any criminal case? (excluding minor traffic infractions, but not DUIs)	☐ Yes	☐ No
10.	Have you ever been convicted of a felony?	☐ Yes	☐ No
11.	Have you ever been disciplined for a violation of ethical standards by a professional organization?	☐ Yes	☐ No

12.	To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐	Yes	☐	No
13.	Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.)	☐	Yes	☐	No
14.	Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	☐	Yes	☐	No
15.	Are you currently in treatment for addiction to drugs or alcohol?	☐	Yes	☐	No
16.	Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug?	☐	Yes	☐	No
17.	Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies?	☐	Yes	☐	No
18.	Do you have any emotional or physical disabilities that may limit your ability to practice?	☐	Yes	☐	No
19.	Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?	☐	Yes	☐	No

SECTION XI
AFFIRMATION OF INFORMATION

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any health plan using this application.

I release _____ "the Health Plan," its representatives, and any individuals or entities providing information to the Health Plan from liability for any act or omission related to the evaluation or verification contained in this application provided the Health Plan, its representatives and individuals providing information to the Health Plan act in good faith and without malice. I further agree to notify the Health Plan of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Health Plan.

I authorize _____ and its agents and any individual or entity providing information to the Health Plan to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

_____

Applicant Signature

_____

Print Name

_____ _____

Print Degree Date

Note: Providers submitting completed credentialing forms to a health plan must complete and submit Section XI as shown. Health plans may, however, substitute their own release and affirmation page in place of this form.

Form **W-9**
(Rev. October 2007)
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
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

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. citizen or other U.S. person (defined below).

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

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

General Instructions

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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

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

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

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

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

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

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

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

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

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

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

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

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

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

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

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

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

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

Exempt Payee

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

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

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

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

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

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[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-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

Privacy Act Notice

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

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

DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR THE STATE OF OHIO

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF OHIO** (hereinafter the "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 the "Network") for the provision of or to arrange for the provision of vision care services (hereinafter "Covered 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 Covered Services on behalf of **DAVIS** to Members of Plan(s) under Plan Contract with **DAVIS**.*****

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

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

.2 "**Clean Claim**" means a claim for payment for 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; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member.

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

.4 "**Covered Families and Children Medicaid**" (hereinafter "CFC") (including Healthy Start, Healthy Families) means a Federal and State financed grant-in-aid program administered by the State providing medical coverage to low-income families, children and pregnant women who meet eligibility

criteria of Chapter 5101:1-39 and 5101:1-40 of the Ohio Administrative Code (hereinafter "OAC").

.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(s) Product, medical eye care, diagnosis, treatment and eye care management services, and ordering and dispensing plan eyeglasses from a **DAVIS** laboratory, when applicable.

.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 statute(s) and/or regulation(s).

.7 "**Healthy Families**" is Ohio's name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services for families who meet certain income limits.

.8 "**Healthy Start**" is the name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services for pregnant women, infants, and children up to specified ages and income limits.

.9 "**Managed Care Organization**" ("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.

.10 "**Medical Assistance Program/Medicaid**" means the joint Federal and State program, administered by 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.

.11 "**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, and if applicable, meet the general principles regarding reimbursement for Medicaid Covered Services set forth in rule 5101:3-1-02 of the Ohio Administrative Code. 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.

.12 "**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.

.13 "**Medically Appropriate/Medical Necessity**." With respect to Plans other than Medicare, Medicare Advantage and Medicaid, the term "Medically Appropriate" means or describes a vision care service(s) or treatment(s)that a **PROVIDER** hereunder, exercising **PROVIDER**'s prudent, clinical judgment would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the "Generally Accepted Standards of Medical Practice"; and is clinically appropriate in terms of type, frequency, extent site and duration; and is considered effective for the Member's illness, injury or disease; and is not primarily for 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.

.14 "**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.

.15 "**Medicare Advantage Member**" means a Member who is enrolled in or who has entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services under a Medicare Advantage Program.

.16 "**Medicare Advantage Program**" shall mean a benefit program/Product established by Plan(s) pursuant to a contract with CMS which complies with all applicable requirements of Part C of the Social Security Act, 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.

.17 "**Member**" 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.

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

.19 "**Non-Covered Services**" means those vision care services which are not Covered Services under Plan Contracts.

.20 "**OAC**" means the Ohio Administrative Code.

.21 "**ODJFS**" means the Ohio Department of Job and Family Services.

.22 "**Participating Provider**" means a licensed health facility which or a licensed health professional who has entered into an agreement with a Plan(s) or with **DAVIS** to provide Medically Appropriate/Medically Necessary 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.

.23 "**Plan(s)**" means health maintenance organizations, Medicare Advantage organizations, Covered Families and Children Medicaid (CFC), Medicaid, 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 Plan Product administered by **DAVIS**.

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

.25 "**Product**" means the vision care, benefit program services that shall be offered to Member(s) by the Plan(s) through Plan Contracts with **DAVIS**.

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

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

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

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

III
SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **CFC Medicaid and Medicaid Members**. **PROVIDER** agrees to identify Members who require the following services, and to provide such services at no cost to Member(s): sign language services and oral interpretation and oral translation services.

.2 **CFC Medicaid and Medicaid Member's Medical Records**. **PROVIDER** agrees to make Member medical records available for transfer to new provider(s) at no cost to Member.

.3 **CFC Medicaid and Medicaid Member's Right to Hearing**. **PROVIDER** agrees to mail or to personally deliver notice of the Member(s)' right to request a State hearing whenever the **PROVIDER** bills a Member for a Non-Covered Service due to denial of payment by **DAVIS** or Plan(s), utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

.4 **CFC Medicaid and Medicaid Member's Right to Anonymity**. **PROVIDER** agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting Member(s) by mail.

.5 **CFC Medicaid and Medicaid Missed Appointments**. **PROVIDER** agrees not to bill CFC Medicaid and Medicaid Members for missed appointments.

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

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

.7 **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.

.8 **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 that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO.

.9 **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** 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 any of the following:

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

(b) Any information the Member needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment versus non-treatment;

(d) The Member's right to participate in decisions regarding his or her vision care, including the right to refuse treatment, and to express preferences about future treatment decisions;

(e) 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

(f) 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.

.10 **Treatment Records**. **PROVIDER** shall (1) establish and maintain a treatment record consistent, in form and content, with generally accepted standards and the requirements of **DAVIS** and Plan(s); and (2) promptly provide **DAVIS** and Plan(s) with copies of treatment records when requested; and (3) shall keep treatment records confidential.

IV
COMPENSATION

.1 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts communicated to **PROVIDER** by **DAVIS** from time to time, and hereby incorporated by reference, as full compensation for the Covered Services provided by **PROVIDER** to Members under an applicable Plan pursuant to this Agreement.

.2 **Copayments, Deductibles and Discount**. **PROVIDER** shall bill and collect all Copayments and Deductibles from Member(s), which are specifically permitted and/or applicable to Member(s)' benefit plan. **PROVIDER** shall bill and collect all charges from a Member for those Non-Covered Services provided to a Member. **PROVIDER** may only bill the Member when **DAVIS** has denied prior authorization for the service(s) and when the following conditions are met:

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

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

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

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

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

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees 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, the MAP, or the ODJFS, 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 plan. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement regardless of the reason for termination, shall be construed to be for the benefit of the Member(s) and shall not be changed without the approval of appropriate regulatory authorities.

.5 **Payment of Compensation**. Payment to **PROVIDER** shall be made within thirty (30) days of receipt of a Clean Claim by **DAVIS, or in accordance with the state's "prompt pay" or similar applicable 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 invoice may 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**. **PROVIDER** agrees that he/she/it shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold each Plan harmless 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, to ODJFS, 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 payor(s) such charges for which the other payor(s) are 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, all applicable rules and regulations, all applicable Federal and State tax laws, as well as the ethical standards of the appropriate professional society. If at any time during the term of this Agreement **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall timely notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and Federal law, as amended, and all regulations issued pursuant

thereto.

.4 **Compliance with Rules, Policies, Administrative Requirements & Procedural Guides**. **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 **DAVIS** Provider Manual. **PROVIDER** recognizes **DAVIS** may, from time to time, amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(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), ODJFS, DHHS, or other government agency, and is not otherwise specified in this Agreement, **PROVIDER** will comply and agrees to require its employees, agents, subcontractors and independent contractors to comply with such policies, manuals, and procedures with regard to the provision of Covered Services to Members of such Programs.

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements; including but not limited to Medicare and Medicaid laws and regulations, CMS instructions and policies, ODJFS regulations, and **DAVIS**' and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals processes, (including OAC Rule 5101:3-26-01) comparative performance analysis, and enforcement and monitoring by appropriate government agencies.

(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 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 the Plan(s) 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 ODJFS and the State of Ohio as described in OAC rule 5101:1-1-03, 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 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. **PROVIDER** shall maintain adequate medical, financial and administrative records related to Covered Services rendered by **PROVIDER**, in accordance with Federal and State law.

.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 contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Members. **PROVIDER** agrees to cooperate with Plan(s)' medical directors in the medical directors' review of the quality of care administered to Members.

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees he/she/it shall be duly licensed and certified under applicable State and Federal statutes and regulations to provide the vision care services that are the subject of this Agreement. **PROVIDER** agrees to provide services within the scope of **PROVIDER**'s license(s) and certification(s) and within the scope of the Plan(s) Product(s) as provided to **PROVIDER**, from time to time, by **DAVIS. PROVIDER** agrees that he/she/it shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE). 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 may include proof of: 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 promptly notify **DAVIS** 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.

(a) In order for **PROVIDER** to provide services to CFC Medicaid and/or Medicaid Members, **PROVIDER** must have a current Medicaid provider number, must meet the qualifications specified in OAC Rule 5101:3-26-05(C), and must not have previously had a Medicaid provider number which was terminated, suspended, denied, or not renewed as a result of any action in accordance with the Ohio Revised Code, the Ohio Administrative Code, CMS, or the Medicaid fraud unit of the office of the Ohio Attorney General.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, DHHS, MAP, ODJFS 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 in the form and format requested and at no cost to **DAVIS** and/or to the requesting Oversight Entity. 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**. **PROVIDER** agrees to be available to provide Covered Services for Medically Appropriate emergency care and shall be accessible twenty- four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year through an answering service or answering machine which provides a pager number. Services not requiring emergency care shall be provided on a timely basis. **PROVIDER** agrees and understands that Plan(s) have the right to approve **DAVIS**' scheduling and administration standards. **PROVIDER** agrees to provide **DAVIS** with ninety (90) days notice, or such notice as is reasonably possible, if **PROVIDER** (a) shall be unavailable to provide Covered Services to Members or (b) is moving his/her/its office location or (c) is reducing 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**.

(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** fail to comply with timely access standards and that Plan(s) have the right to approve **DAVIS**' scheduling and administration standards.

(b) Pursuant to and in accordance with 42 CFR 438.206(c)(2), **PROVIDER** agrees 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.

.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, subcontractors, or independent contractors.

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement, maintain a policy of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants or employees, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy is a "claims made" policy, **PROVIDER** shall maintain "tail coverage," with the same liability limits, following the effective termination date of the foregoing policy.

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s)s covered under one or more of the Plans or in conflict with the terms of this Agreement. 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 Americans with Disabilities Act, **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, 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. 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. **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 Section 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 Universal Provider Identification Number and/or 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.

(c) **PROVIDER** understands that payments may be derived from Federal and State funds, and that **PROVIDER** shall be civilly and/or criminally liable to both Plan(s) and government agencies for non-performance, non-compliance, misrepresentation, fraud or abuse of Covered Services rendered hereunder. **PROVIDER** shall comply with all Federal, State, municipal, and local laws, rules and regulations applicable to his/her/its activities in rendering Covered Services to Members under this Agreement; including without limitation Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Sections 2000d *et seq.*); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Sections 701 *et seq.*); the Age Discrimination Act of 1975 (42 U.S.C. Sections 6101 *et seq.);* the provisions of the Americans with Disabilities Act (42 U.S.C. Sections 12101 *et seq.*); and general provisions relating to nondiscrimination, sexual harassment or fraud and

abuse, as well as all applicable laws pertaining to the receipt of Federal and State funds.

.16 **Provider Roster**. **PROVIDER** agrees that **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER'**s name, address, phone number, type of practice, and willingness to accept new patients in the **DAVIS** or Plan roster of Participating Providers. The roster may be inspected, may be used by, and is intended for use 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** agrees 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) Pursuant to OAC Rules 5101:3-26 and 5101:3-26-06(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 subcontractors and independent contractors, in accordance with applicable sections of the Federal regulations and the Ohio Administrative Code. 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) 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 be automatically renewed for up to, but not more than, three (3) successive twelve (12) month terms on the same terms and conditions contained herein.

VII
TERMINATION OF THE AGREEMENT

.1 **MCO Non-Renewal or Termination**. Notwithstanding anything herein to the contrary, the MCO must give the **PROVIDER** at least sixty (60) days prior, written notice for non-renewal or termination of this Agreement except in cases where a successful prosecution of **PROVIDER** under CFC Medicaid or Medicaid laws/regulations has occurred, or where there is an adverse finding by a regulatory agency or where a quality of care concern dictate that the Agreement be sooner terminated. If the MCO issues a notice to non-renew and/or terminate the Agreement due to any of the foregoing, the MCO must so notify the ODJFS within one (1) working day of issuing such notice. MCO shall also make a good faith effort to give written notice of non-renewal and/or termination of a **PROVIDER**, within fifteen (15) calendar days after receipt of or issuance of such notice, to each Member who received his or her primary care from, or was seen on a regular basis by the terminated **PROVIDER**.

.2 **Provider Non-Renewal or Termination**. Notwithstanding anything herein to the contrary, the **PROVIDER** may non-renew and/or terminate this Agreement if:

(a) The **PROVIDER** provides the MCO with at least sixty (60) days prior, written notice for the non-renewal and/or the termination of this Agreement and the effective date for the non-renewal and/or termination must be the last day of the month; OR

(b) The ODJFS has proposed action, in accordance with OAC Rule 5101:3-26-10(G) regardless of whether the action is appealed or whether a quality of care concern dictates that the Agreement be terminated sooner than sixty (60) days. The **PROVIDER**'s non-renewal and/or termination notice must be received by the MCO within fifteen (15) working days prior to the end of the month in which the **PROVIDER** is proposing non-renewal and/or termination. If the notice is not received by this date, the **PROVIDER** must extend the non-renewal and/or termination date to the last day of the subsequent month.

(c) If the MCO receives the **PROVIDER**'s notice to non-renew and/or to terminate this Agreement due to an action proposed by the ODJFS and in accordance with OAC Rule 5101:3-26-10(G) or for a quality of care concern, the MCO agrees to notify the ODJFS within one (1) working day of the receipt of the **PROVIDER**'s written notice.

(d) **PROVIDER** agrees to serve Members through the last day this Agreement is in effect.

(e) The procedures to be employed upon the ending, non-renewal, or termination of this Agreement apply to this Section VII.2, including the **PROVIDER**'s agreement to promptly supply all records necessary for the settlement of outstanding medical claims.

.3 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement without cause, pursuant to this Agreement, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify said Member(s) of the termination prior to its effective date.

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

.5 **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 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(s) 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.5, prior to and following the effective termination date of this Agreement, at the rates contemplated in this Agreement for Covered Services.

(a) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement for reasons other than for cause, **PROVIDER** shall comply with Medicare and ODJFS continuity of care provisions and regulations. The parties agree that any Member, at the Member's option, may continue an ongoing course of treatment with **PROVIDER** for a transitional period of up to sixty (60) days from the date the Member is notified of the termination or the pending termination.

(b) In consultation with Plan(s), 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.

(c) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement, **PROVIDER** shall comply with applicable **PROVIDER** obligations as set forth in Section VII of this Agreement.

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

.6 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. Upon termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including,

but not limited to, frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** may reclaim frame samples at any time during the term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding claims.

.7 **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:

.7.1 A decision by **DAVIS** and/or Plan(s) to discontinue its/their participation in the Medicare Advantage Programs; or

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

.7.3 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

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

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

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

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

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

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

(e) conviction of a felony;

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

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

(h) the bankruptcy of **PROVIDER**; and/or

(i) a successful prosecution of **PROVIDER** under the CFC Medicaid and/or Medicaid laws/regulations.

"Cause" for the purposes of suspension shall mean:

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

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

(c) a failure by **PROVIDER** to comply with policies, administrative requirements and procedural guides as required in Section V.4 hereof; or a failure to comply with participation criteria as required in Section V.15 hereof;

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

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

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

.9 **Termination Without Cause**. After the initial twelve (12) month term this Agreement may be terminated by either party, without cause, upon ninety (90) days prior written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a term hereof, or for a reason other than those set forth in this Section VII, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request.

VIII
AMENDMENT AND DOCUMENTATION

.1 **Amendment**. **DAVIS** may amend this Agreement with thirty (30) days advance, written notice to **PROVIDER**.

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

.3 **Modifications of Laws/Regulations**. As respects CFC and Medicaid, ODJFS shall notify the MCO and/or the Plan(s), and **DAVIS** of any changes in applicable State or Federal laws, regulations, waiver, or contractual obligation of the MCO and/or the Plan(s) and **DAVIS**; and **DAVIS** shall notify **PROVIDER** of such changes. This Agreement shall automatically amend to conform to such changes without the necessity for executing written amendments.

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

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

.6 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider Services for Medicare Advantage, CFC Medicaid and Medicaid Program Members. Further, **PROVIDER** shall comply with the ODJFS external quality review as described in OAC rule 5101:3-26-07.

X
GENERAL PROVISIONS

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

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

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

.4 **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.

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

.6 **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.

.7 **Independent Contractor**. At all times relevant to and pursuant to the terms and conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER'**s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

.8 **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 SectionX.8 shall be grounds for immediate termination of this Agreement.

.9 **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.

.10 **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.

.11 **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.

.12 **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.

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

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

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

PROVIDER:

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

(PROVIDER MUST sign and complete all spaces above.)

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

DAVIS VISION, INC.:

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

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

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