



**CREDENTIALING DOCUMENT REQUIREMENTS  
FOR NETWORK PARTICIPATION**

**STATE OF OKLAHOMA**

**Complete all information and provide documents listed below.\*** to provide services shall be granted prior to an applicant’s satisfactory completion of the credentialing process.

**A valid National Provider Identifier number is a required element of the application process.** Provide your \_ number on the application. Provide your NPI number either on the application or include documentation of your Organizational NPI number from CMS on a separate sheet.

\_\_\_\_\_

**APPLICATION**

**Uniform Credentialing Application, Oklahoma ODH Form 606  
Revise 05/30/08**

\_\_\_\_\_

**PARTICIPATING PROVIDER AGREEMENT^**

^All applicants/practitioners sign and complete all information required on the signature of the Participating Provider Agreement, and return the signed (complete), original Provider to Davis Vision.

\_\_\_\_\_

**COPY OF ALL CURRENT STATE REGISTRATIONS**

\_\_\_\_\_

**COPY OF DEA CERTIFICATE, IF APPLICABLE**

\_\_\_\_\_

**COPY OF CSR CERTIFICATE, IF APPLICABLE**

\_\_\_\_\_

**COPY OF BOARD CERTIFICATION, IF APPLICABLE**

\_\_\_\_\_

**COPY OF CURRICULUM VITAE OR RESUMÉ**

\_\_\_\_\_

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

\_\_\_\_\_

**COPY OF BLANK PATIENT EXAM FORM**

\_\_\_\_\_

**W-9 FORM**

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



## Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

Dear Health Care Professional:

In 1998, the Oklahoma Legislature passed a law dealing with credentials verification. That law directed the Board of Health to promulgate rules and the Oklahoma State Department of Health to develop a uniform credentialing application. The application will be used to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

The Department developed the Uniform Credentialing Application. Although many of the items apply primarily to physicians, this form is designed for use by all health care professionals.

**Please note these specific instructions:**

- 1. DO NOT submit this form to the Oklahoma State Department of Health.**
- 2. Contact the facility or organization to which you plan to apply before submitting this form to find out what addendum, supplemental form, additional information, or additional items will be required.**
- 3. All items must be completed.**
- 4. If an item is not applicable, please so state.**
- 5. Please print legibly or type.**
- 6. Be sure to sign and date the application.**
- 7. If additional space is needed, please attach additional sheets.**

The application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. The form is available on the Department's website at <http://hrds.health.ok.gov>. For questions about the form you may contact the Department at (405) 271-6868. The form may also be available online at the different facilities and organizations to which you will be making application.

Protective Health Services  
Oklahoma State Department of Health



Health Resources  
Development Service  
Oklahoma State  
Department of Health

Managed Care Systems  
1000 NE 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
Phone 405.271.6868  
Fax 405.271.7360

## Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

**This form must be completed in full and typed or printed legibly (i.e. do not state “see CV”). Write “N/A” in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.**

Name of facility/organization this application will be submitted to: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

**SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.**

**SECTION 1: PERSONAL INFORMATION**

Name \_\_\_\_\_  
Last First Middle Suffix  
Professional Degree \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Other Name By Which You Have Been Known \_\_\_\_\_  
Dates This Name Was Used: From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_

Other Name By Which You Have Been Known \_\_\_\_\_  
Dates This Name Was Used: From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_

Social Security Number \_\_\_ - \_\_\_ - \_\_\_ NPID (formerly UPIN) \_\_\_\_\_

Date of Birth: \_\_\_ - \_\_\_ - \_\_\_ Place of Birth \_\_\_\_\_ Citizenship \_\_\_\_\_

\_\_\_\_\_  
Visa Type Visa Number (provide copy) Expiration Date

\_\_\_\_\_  
Your Personal Medicare Number Your Personal Medicaid Number

**SECTION 2: DIRECTORY INFORMATION**

**Mailing Address For All Credentialing Correspondence:** \_\_\_\_\_  
Street Address

\_\_\_\_\_  
Suite Number City State Zip Code  
( ) ( ) ( )

Phone Number Fax Number Emergency or Pager Number  
( )

Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: \_\_\_\_\_

**This Section continues on next page.**

**-Section 2 Continued-**

**Office Street Address:** \_\_\_\_\_  
Street Address

Suite Number	City	State	Zip Code
( )		( )	( )
Phone Number		Fax Number	Emergency or Pager Number
( )			
Answering Service Number		E-Mail Address	

**Office Mailing Address:** \_\_\_\_\_  
Street Address

Suite Number	City	State	Zip Code
( )		( )	( )
Phone Number		Fax Number	Emergency or Pager Number
( )			
Answering Service Number		E-Mail Address	

**Office Billing Address (If Different From Claims Payment Address):** \_\_\_\_\_  
Street Address

Suite Number	City	State	Zip Code
( )		( )	( )
Phone Number		Fax Number	Emergency or Pager Number
( )			
Answering Service Number		E-Mail Address	

**Claims Payment Address (If Different From Office Billing Address):** \_\_\_\_\_  
Street Address

Suite Number	City	State	Zip Code
( )		( )	( )
Phone Number		Fax Number	Emergency or Pager Number
( )			
Answering Service Number		E-Mail Address	

Make Checks Payable To: \_\_\_\_\_

### SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice)	Subspecialty	% Of Time
--	--------------	-----------

Secondary Specialty	Subspecialty	% Of Time
---------------------	--------------	-----------

Do you wish to be listed as:  
 Primary Care Provider     Specialist     Hospitalist     On-Call     Other (specify) \_\_\_\_\_

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

Yes  No Are you accepting new patients?

Yes  No Are you willing, in the future to accept new patients?

Yes  No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

Yes  No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

Yes  No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: \_\_\_\_\_

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

( )	( )	( )
-----	-----	-----

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

Name: \_\_\_\_\_

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

( )	( )	( )
-----	-----	-----

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

List any restrictions on your practice (i.e. patient age and gender): \_\_\_\_\_

## SECTION 4: EDUCATION

### Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1)	Institution		Degree Awarded
	Mailing Address	City	State    Zip Code
	Telephone Number: (        ) _____		
	Dates Attended (mo/day/year) From: ____ - ____ - _____ to ____ - ____ - _____		
	Graduation Date ____ - ____ - _____		
(2)	Institution		Degree Awarded
	Mailing Address	City	State    Zip Code
	Telephone Number: (        ) _____		
	Dates Attended (mo/day/year) From: ____ - ____ - _____ <b>to</b> ____ - ____ - _____		
	Graduation Date ____ - ____ - _____		
(3)	Institution		Degree Awarded
	Mailing Address	City	State    Zip Code
	Telephone Number: (        ) _____		
	Dates Attended (mo/day/year) From: ____ - ____ - _____ <b>to</b> ____ - ____ - _____		
	Graduation Date ____ - ____ - _____		

## SECTION 5: TRAINING

### Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed:  Yes  No

Specialty	Institution	Your Program Director	
		( )	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(2) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director	
		( )	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(3) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director	
		( )	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(4) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director	
		( )	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			



## SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1)		( )		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(2)		( )		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(3)		( )		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			

## SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, all hospital/health system affiliations where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your “current primary and secondary admitting facility” (where you currently spend the greatest portion of your time).

(1)		___ Primary	___ Secondary
	Facility Name		
		( )	
	Complete Mailing Address	City	State
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	
(2)		___ Primary	___ Secondary
	Facility Name		
		( )	
	Complete Mailing Address	City	State
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	

**This section continues on next page.**

**-Section 7 Continued-**

(3) \_\_\_\_\_ Primary \_\_\_ Secondary  
 Facility Name  
 \_\_\_\_\_  
 Complete Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Dates of Appointment (mo/day/year) Staff Category  
 \_\_\_\_\_  
 Reason for Discontinuance Department or Service

**SECTION 8: OTHER PROFESSIONAL WORK HISTORY**

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) \_\_\_\_\_  
 Name and Nature of Affiliation  
 \_\_\_\_\_  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) \_\_\_\_\_  
 Name and Nature of Affiliation  
 \_\_\_\_\_  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) \_\_\_\_\_  
 Name and Nature of Affiliation  
 \_\_\_\_\_  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

**US Military/Public Health Service**

List all medical and surgical locations and dates.

From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_  
 Location Branch of Service  
 From: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_  
 Location Branch of Service

## SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

<u>Oklahoma</u>					
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
USMLE/ECFMG Number			Certification Date		
_____			____-____-____		

## SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.  
 (DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

	<u>DEA</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
Oklahoma	<u>BNDD</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	

### BOARD CERTIFICATION

Are you Board Certified?     Yes     No    \_\_\_\_\_  
 Name of Board

\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
 Date Initially Certified    Date Most Recently Recertified    Date Certification Expires

Yes     No    Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

**This section continues on next page.**

**-Section 10 Continued-**

**SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS**

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____	____ - ____ - ____	____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____	____ - ____ - ____	____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

**BOARD QUALIFICATIONS**

\_\_\_ Yes \_\_\_ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

\_\_\_ Yes \_\_\_ No Are you planning to take the exam?

\_\_\_ Yes \_\_\_ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Written \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Other \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Subspecialty or Added Qualification	Name of Board
Date Qualified ____ - ____ - ____	Date Qualification Expires ____ - ____ - ____

Classifications:

\_\_\_ Yes \_\_\_ No Are you certified in CPR? Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Basic Life Support (BLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Advanced Cardiac Life Support (ACLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Health Care Provider (CoreC) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Advanced Trauma Life Support (ATLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Neonatal Advanced Life Support (NALS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Pediatric Advanced Life Support (PALS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Other \_\_\_\_\_ Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## SECTION 11: OFFICE INFORMATION

### Primary Office

Group Name \_\_\_\_\_ Name As It Appears On Your W-9 (if applicable) \_\_\_\_\_ Business Owned By \_\_\_\_\_

Type of Practice:  
 Solo  Partnership  Single-Specialty Group  Multi-Specialty Group Other (specify) \_\_\_\_\_

Office Manager \_\_\_\_\_ Nurse Coordinator \_\_\_\_\_

Group Medicare Number \_\_\_\_\_ Group Medicaid Number \_\_\_\_\_ IRS Tax ID Number \_\_\_\_\_

Does this office have lab service?  Yes  No Reference Lab?  Yes  No On Site?  Yes  No

CLIA ID # \_\_\_\_\_ CLIA Waiver # \_\_\_\_\_

Does your office have the following:

Yes  No Radiology  
 Yes  No EKG  
 Yes  No Audiology  
 Yes  No Treadmill  
 Yes  No Sigmoidoscopy  
 Yes  No Wheelchair/handicapped access?  
 Yes  No Other services for the disabled?

If yes, please list: \_\_\_\_\_  
 Yes  No Other: \_\_\_\_\_

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:  
 You \_\_\_\_\_  
 Your Staff \_\_\_\_\_  
 Other Resources \_\_\_\_\_

Yes  No Does this office meet all state and local fire, safety and sanitation requirements?  
 Yes  No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.  
**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Yes  No Do you or your business own, operate, manage or participate in any medical enterprise or business?  
 If yes, explain on a separate attachment.

## SECTION 11: OFFICE INFORMATION

### Secondary Office

Group Name \_\_\_\_\_ Name As It Appears On Your W-9 (if applicable) \_\_\_\_\_ Business Owned By \_\_\_\_\_  
 Type of Practice:  
 Solo  Partnership  Single-Specialty Group  Multi-Specialty Group  Other (specify) \_\_\_\_\_

Office Manager \_\_\_\_\_ Nurse Coordinator \_\_\_\_\_

Group Medicare Number \_\_\_\_\_ Group Medicaid Number \_\_\_\_\_ IRS Tax ID Number \_\_\_\_\_  
 Does this office have lab service?  Yes  No Reference Lab?  Yes  No On Site?  Yes  No

CLIA ID # \_\_\_\_\_ CLIA Waiver # \_\_\_\_\_

Does your office have the following:  
 Yes  No Radiology  
 Yes  No EKG  
 Yes  No Audiology  
 Yes  No Treadmill  
 Yes  No Sigmoidoscopy  
 Yes  No Wheelchair/handicapped access?  
 Yes  No Other services for the disabled?  
 If yes, please list: \_\_\_\_\_  
 Yes  No Other: \_\_\_\_\_

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:  
 You \_\_\_\_\_  
 Your Staff \_\_\_\_\_  
 Other Resources \_\_\_\_\_

Yes  No Does this office meet all state and local fire, safety and sanitation requirements?  
 Yes  No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____

Yes  No Do you or your business own, operate, manage or participate in any medical enterprise or business?  
 If yes, explain on a separate attachment.

## SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

<u>Attached</u>	<u>Item</u>
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

## SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:**

**Practitioners are reminded that each organization will require submission of additional information.**

## SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

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**AUTHORIZATION, ATTESTATION AND RELEASE**

I acknowledge, understand, and agree that as an applicant for provider participation status with Davis Vision, Inc. for either initial credentialing, or re-credentialing or update of information, I have the burden of producing adequate information for the proper evaluation of my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental health status, physical health status, alcohol or chemical dependency diagnosis and treatment, or other criteria used for determining eligibility for participation status with Davis Vision, Inc.

I affirm that the information provided in this Application for participation status is current, accurate, and complete as of the signature date below, and I understand and agree that any misstatements in and/or omissions from the information provided herein may constitute cause for denial of my Application and/or summary dismissal or termination of participation status with Davis Vision, Inc., and I further agree to immediately notify Davis Vision, Inc. of any change to the information provided in this Application. I understand that any information provided in this Application that is not publicly available will be treated as confidential by Davis Vision, Inc., unless otherwise permitted by law to be disclosed.

I further acknowledge, understand, and agree that Davis Vision, Inc., its employees and agents will investigate the information in this Application, as well as any oral and written statements, records and documents concerning my Application for participation status, and I agree to such investigation and to the disciplinary reporting and information exchange activities of Davis Vision, Inc. as part of the verification and credentialing process.

I consent to the inspection of all oral and written statements, records and documents that may be material to an evaluation of my qualifications and to my ability to carry out or to provide the services required or requested for participation status, and I authorize each and every individual and organization in custody of such statements, records and documents to permit such inspection and copying; and I further agree to permit Davis Vision, Inc. to source verify credentials and to access the National Practitioners Data Bank (NPDB) and other pertinent sources for history; and I further consent and am willing to make myself available to appear for interviews if required or requested.

I authorize Davis Vision, Inc. and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staff of hospitals, malpractice insurance carriers, licensing boards, professional and/or educational organizations, and other person(s) to obtain and verify information; and I further release Davis Vision, Inc. and its employees and agents from any and all liability for their acts performed in good faith and without malice or misconduct, in obtaining and verifying such information and in evaluating my Application.

I consent to the release, by any person to Davis Vision, Inc., of any and all information that may be reasonably relevant to an evaluation of my professional competency, character, ability to practice in the areas in which I have requested privileges, and to my moral and ethical qualifications, including any information relating to any disciplinary action, suspension, limitation, or revocation of privileges.

I hereby release from any and all liability, each and every individual, organization, and/or third party that, in good faith and without malice or misconduct, provides information to Davis Vision, Inc., concerning my professional qualifications and competence.

I further acknowledge, understand, and agree that this authorization and consent to release information is for the purpose of permitting Davis Vision, Inc., its employees and agents to update my data, conduct office and record reviews and to conform with the National Committee for Quality Assurance (NCQA) standards, and that this authorization is irrevocable for any period of time during which I am an applicant for, or a provider in, the Davis Vision, Inc. network; and I agree to execute another form of authorization and consent if law or regulation limits the application of this irrevocable authorization; and I understand that my failure to promptly execute and provide such other authorization and consent may be grounds for termination or discipline by Davis Vision, Inc. in accordance with Davis Vision's rules and requirements for network participation status.

I acknowledge, understand, and agree that neither the submission of a completed Application nor the execution of the Davis Vision Participating Provider Agreement constitutes acceptance as a Davis Vision Participating Provider. Acceptance as a Davis Vision Participating Provider is contingent on the acceptance by Davis Vision, Inc. of an applicant's completed Application, and on the execution by the applicant of the Davis Vision Participating Provider Agreement, and on the receipt by the applicant of the forms, manual and samples required for participation. Davis Vision, Inc. reserves the absolute right to determine which applicant is acceptable for participation and in which groups an applicant will participate.

I acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, Davis Vision, Inc. may report the rejection to the appropriate state licensing board and/or the NPDB. A photocopy of this Authorization, Attestation and Release shall be as effective as the original, and this authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application/Authorization, Attestation and Release.

I understand that the provider's Bill of Rights and non-discrimination policy is available for viewing at [www.davisvision.com](http://www.davisvision.com).

**\*Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**\*Print Name:** \_\_\_\_\_

\*(Applicant/Practitioner must sign and print name in full. Modification to the wording or format of this Authorization, Attestation and Release of Information may invalidate Application.)

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶	
	<input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number									

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

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.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

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

#### Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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

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

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

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

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

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

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

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

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

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

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

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

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage 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.

### **Updating Your Information**

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

### **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/disregarded entity name” line.

**Partnership, C Corporation, or S Corporation.** Enter the entity's name on the “Name” line and any business, trade, or “doing business as (DBA) name” on the “Business name/disregarded entity name” line.

**Disregarded entity.** Enter the owner's name on the “Name” line. The name of the entity entered on the “Name” line should never be a disregarded entity. The name on the “Name” line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the “Name” line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the “Business name/disregarded entity name” line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

**Note.** Check the appropriate box for the federal tax classification of the person whose name is entered on the “Name” line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

**Limited Liability Company (LLC).** If the person identified on the “Name” line is an LLC, check the “Limited liability company” box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter “P” for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter “C” for C corporation or “S” for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the “Name” line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the “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/disregarded entity name" line.

## 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/disregarded entity 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 following chart 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 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, 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](http://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](http://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 [IRS.gov](http://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 item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

**Signature requirements.** Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

**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 <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee <sup>1</sup> The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

<sup>1</sup> 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.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

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

<sup>4</sup> 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. Grantor also must provide a Form W-9 to trustee of trust.

**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.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

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](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS 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](mailto:spam@uce.gov) or contact them at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 1-877-IDTHEFT (1-877-438-4338).

Visit [IRS.gov](http://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 (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and 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. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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

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

**RECITALS**

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

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

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

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

**I  
PREAMBLE AND RECITALS**

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

**II  
DEFINITIONS**

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

.2 “**Clean Claim**” means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS**, referencing a specific Member and Member’s information; (b) a valid, **DAVIS**-assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation

was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax identification number not documented on a properly completed W-9 form are not Clean Claims. Further, submission of a properly completed CMS Form 1500 or any applicable Uniform Claim Form and any attachments approved or adopted for use in the applicable jurisdiction for payment of Covered Services and as promulgated by the rules and regulations of said jurisdiction shall be deemed a Clean Claim.

.3 “**Copayment**”, “**Coinsurance**”, or “**Deductible**” means those charges for vision care services, which are the responsibility of the Member under a benefit program and 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. Such charges are herein also referred to as “cost sharing” as pertains to charges for which a dually eligible Medicare Advantage Subscriber is responsible.

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

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

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

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

.8 “**Medical Assistance Program**” (hereinafter “MAP”) means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States



for Medical Assistance Programs, Section 1396 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

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

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

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

- (a) The Covered Service is required in order to diagnose or treat the Member’s medical condition (the convenience of the Member, of the Member’s family or of the Participating Provider is not a factor to be considered in this determination); and
- (b) The Covered Service is safe and effective: (i.e. the Covered Service must)
  - (i) be appropriate within generally accepted standards of practice;
  - (ii) be efficacious, as demonstrated by scientifically supported evidence;

- (iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and
- (iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

(c) The Covered Service is the least costly alternative course of diagnosis or treatment that is adequate for the Member's medical condition; factors to be considered include, but are not limited, to whether the Covered Service can be safely provided for the same or lesser cost in a medically appropriate alternative setting; and

(d) The Covered Service, or the specific use thereof, for which coverage is requested is not experimental or investigational. A service or the specific use of a service is investigational or experimental if there is not adequate, empirically-based, objective, clinical scientific evidence that it is safe and effective. This standard is not met by (i) a Participating Provider's subjective medical opinion as to the safety or efficacy of a service or specific use or (ii) a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating a different condition. Use of a drug or biological product that has not received FDA approval is experimental. Off-label use of a drug or biological product that has received FDA approval is experimental unless such off-label use is shown to be widespread and generally accepted in the medical community as an effective treatment in the setting and condition for which coverage is requested.

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

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

.13 "**Medicare Advantage Member**" or "**Medicare Advantage Subscriber**" means an individual who is enrolled in and covered under a Medicare Advantage Program or any successor program(s) thereto regardless of the name(s) thereof. Dually eligible Medicare Advantage Subscribers are those individuals who are (i) eligible for Medicaid; and (ii) for whom the state is responsible for paying Medicare Part A and B cost sharing.

.14 "**Medicare Advantage Program**" means a product established by Plan pursuant to a contract with the CMS which complies with all applicable requirements of Part C of Title 42 of

United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 *et seq*, as amended from time to time, and which is available to individuals entitled to and enrolled in Medicare or any successor program(s) thereto regardless of the name(s) thereof.

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

.16 “**Negative Balance**” means receipt of Copayments, Coinsurances, Deductibles or other compensation by **PROVIDER** or Participating Provider which are in excess of the amounts that are due to **PROVIDER** or Participating Provider for Covered Services under this Agreement.

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

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

.19 “**Overpayment**” means an incorrect claim payment made to a **PROVIDER** or Participating Provider via check or wire transfer due to one or more of the following reasons: (i) a **DAVIS** processing error (ii) an incorrect or fraudulent claim submission by **PROVIDER** or Participating Provider (iii) a retroactive claim adjustment due to a change, oversight or error in the implementation of a fee schedule.

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

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

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

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

.24 “**State**” means the State in which **PROVIDER**’s practice is located or the State in which the **PROVIDER** renders services to a Member.

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

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

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

### III

#### SERVICES TO BE PERFORMED BY THE PROVIDER

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

- (a) **PROVIDER** agrees the frame collection will be shown to all Members receiving eyeglasses under the Plan.
- (b) **PROVIDER** agrees the frame collection shall be openly displayed in an area accessible to all Members.
- (c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was delivered less any normal deterioration.
- (d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.

- (e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and at any other time upon reasonable notice. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.
- (f) At any time and upon reasonable notice **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.
- (g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume the full cost of the display and/or the frame collection and will be required to reimburse **DAVIS** its/their fair market value.

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

In addition, **DAVIS** and **PROVIDER** are prohibited, throughout the Term(s) of this Agreement, from instituting gag clauses for their employees, contractors, subcontractors, or agents that would limit the ability of such person(s) to share information with Plan(s) and/or any regulatory agencies regarding the Medical Assistance MCO Program(s) and the Medicare Program(s).

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

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

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

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

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

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

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

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

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

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

## IV COMPENSATION

.1 **Billing**. 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** a Clean Claim which, may be written, electronic or verbal. shall be approved as to form and content by **DAVIS**, and if applicable shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit said invoice within sixty (60) days of service delivery will, at **DAVIS**' option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered.

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

(a) In accordance with 42 CFR §422.504(g)(1)(iii), and to the extent applicable, **PROVIDER** agrees that dually eligible Subscribers of Medicare Advantage plans shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate State Medicaid agency is liable for the cost-sharing. **PROVIDER** further agrees that upon receiving payment from **DAVIS** for a Medicare Advantage Subscriber, **PROVIDER** will either: (i) Accept the Medicare Advantage payment as payment in full; or (ii) Bill the appropriate State source.

.3 **Copayments, Coinsurance, Deductibles and Discounts**. **PROVIDER** shall bill and collect all Copayments, Coinsurances 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 confirmation of eligibility 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.

.4 **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.

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

.6 **Payment of Compensation.** Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS** or in accordance with the applicable state's prompt pay statute, whichever is most restrictive. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment, Coinsurances, and Deductibles collected or to be collected from the Member. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

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

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



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

.9 **Overpayment Recovery.** At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment. **PROVIDER** shall be responsible to remit payment on such an Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when legally permissible, automatically apply the Overpayment to other outstanding payables on **PROVIDER**'s account. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS**' network in accordance with the suspension and termination provisions set forth in this Agreement. Notwithstanding the foregoing, should this provision conflict with any applicable rules and regulations, said rules and regulations shall govern. Notwithstanding the foregoing, **DAVIS**' Overpayment recovery efforts shall comply with any legislative or statutory timeframe(s) specified within the jurisdiction where services were provided.

## V OBLIGATIONS OF PROVIDER

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

- .1.1 any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and
- .1.2 any information necessary for Plan(s) to administer and evaluate program(s); and
- .1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d)

- to report health outcomes; and
- .1.4 any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies under 42 CFR §422.210; and
  - .1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 C.F.R. §§ 422.516 and 422.310, and all other sections of 42 CFR. §422 relevant to reporting obligations; and
  - .1.6 **PROVIDER** shall certify (based upon best knowledge, information and belief) the accuracy, completeness and truthfulness of **PROVIDER**-generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to CMS; and
  - 1.7 **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

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

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

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

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements, including but not limited to: Medicare, Medicare Advantage (and any successor program thereto), Medicaid and MAP laws and

regulations, CMS instructions and policies; agrees to audits and inspections by the CMS and/or its designees and shall cooperate, assist, and provide information as requested; and agrees to comply with **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, comparative performance analysis, and enforcement and monitoring by appropriate government agencies, and activities necessary for the external accreditation of **DAVIS** and/or Plan(s) by the National Committee for Quality Assurance or any other similar organization selected by **DAVIS** and/or Plan(s). Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP which shall, on an ongoing basis, monitor performance under this Agreement to ensure the performance of the Parties is consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the State MAP and the MCO.

(c) In relation to the provision of Covered Services to Medicare and Medicare Advantage Members and Plan(s) hereunder, **PROVIDER** and **PROVIDER's** employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare Advantage credentialing and re-credentialing requirements and processes and agree to all of the following: **DAVIS** and Plan(s) are ultimately accountable and responsible to the CMS for services delivered and performed by **PROVIDER** hereunder; all services delivered and performed by **PROVIDER** hereunder must be delivered and performed in accordance with the requirements of Plan agreements with the CMS and with Medicare laws and regulations; such services shall, on an ongoing basis, be monitored by the Plan(s) and/or the CMS and their respective delegates; the Plan(s) and/or the CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s); the Managed Care Organization (MCO) is accountable to the CMS for any functions and responsibilities described in the Medicare regulations pursuant to 42 CFR §422.504; and **PROVIDER** is required to comply with the MCO's policies and procedures.

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

.5 **Confidentiality of Member Information.** **PROVIDER** agrees to abide by all

Federal and State laws regarding confidentiality, including unauthorized uses of or disclosures of patient information and personal health information.

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

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

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

.6 **Consent to Release Information.** Upon request by **DAVIS** **PROVIDER** shall provide **DAVIS** with authorizations, consents or releases, 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 contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and in certain instances Plans 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,

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

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

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

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

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

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

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

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

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such

patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall comply with the “General Prohibitions Against Discrimination,” 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the regulations implementing the Americans with Disabilities Act (“ADA”), 28 CFR §35.101 et seq., **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member’s race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of Federal funds including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (“Revised DHHS LEP Guidance”); and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the Term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee’s or applicant’s hire, tenure, terms, conditions, or privileges of employment due to such individual’s race, color, religion, gender, disability, marital status or national origin.

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

.15 **Participation Criteria.** **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**’s employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal laws designed to prevent or ameliorate fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§422.504(h)(1), 423.505(h)(1), and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **PROVIDER** hereby warrants and represents **PROVIDER** and all of **PROVIDER**’s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from

participation under a federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier number, as applicable.

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

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

.16 **PROVIDER Directory.** **PROVIDER** understands and agrees **DAVIS** and Plan(s) reserve the right to use **PROVIDER**'s name, address, telephone number, type of practice, and willingness to accept new patients for the purposes of printing and distributing provider directories to Member(s). Such directories are intended for and may be inspected and used by prospective patients and others.

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

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to safeguard and maintain, in an accurate and timely manner, contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agrees to provide such information to **DAVIS**, contracting Plans, applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. In the case of a minor



Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. **PROVIDER** shall make available premises, physical facilities, equipment, records and any relevant information the CMS may require which pertains to Covered Services provided to Medicare Advantage Program Members. **PROVIDER** and Participating Provider(s) shall cooperate with any such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and shall make appropriate practitioner(s), employees, and involved parties available for interviews, as requested. Such records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

(b) All hard copy or electronic records, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, which are originated or are prepared in connection with and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicaid program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the federal and State regulations. Records stored electronically must be produced at the **PROVIDER**'s expense, upon request, in the format specified by State or federal authorities. All such records must be maintained for a minimum of ten (10) years from the termination date of this Agreement or, in the event that the **PROVIDER** has been notified that State or federal authorities have commenced an audit or investigation of this Agreement, or of the provision of services by the **PROVIDER**, or by **PROVIDER**'s subcontractor or independent contractor, all records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

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

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

(a) an agreement by the subcontractor or leaseholder to comply with all of **PROVIDER**'s obligations in this Agreement; and

(b) a prompt payment provision as negotiated by **PROVIDER** and the subcontractor or leaseholder; and

(c) a provision setting forth the terms of payment, any incentive arrangements, and any additional payment arrangements; and

(d) a provision setting forth the term of the subcontract or lease (preferably a minimum of one [1] year); and

(e) the dated signature of all parties to the subcontract.

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

.20 **Verification of Eligibility.** **DAVIS** shall make available to **PROVIDER** a system for determining eligibility of Members seeking services under benefit programs hereunder. **PROVIDER** agrees to comply with the eligibility system requirements and to obtain a valid, confirmation of eligibility number prior to rendering services to any Member. To verify eligibility of Member(s) **PROVIDER** shall call the appropriate toll-free (800/888) number supplied by **DAVIS**, or access the **DAVIS** website (www.davisvision.com), or receive from Member(s) a valid pre-certified voucher. In order for **PROVIDER** to receive reimbursement for services rendered to a Member, services must be provided within the timeframe communicated to **PROVIDER** upon receipt of a confirmation of eligibility number, or upon **PROVIDER**'s receipt of an extension of the original confirmation of eligibility number. Neither **DAVIS** nor Plan(s) shall have any obligation to reimburse **PROVIDER** for any services rendered without a valid confirmation of eligibility number. However, if **DAVIS** provides erroneous eligibility information to **PROVIDER**, and if benefits under the program(s) are provided to a Member, **DAVIS** shall reimburse **PROVIDER** for any benefits provided to a Member.

## VI TERM OF THE AGREEMENT

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

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

## VII TERMINATION OF THE AGREEMENT

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

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

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

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

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

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

(e) a conviction of a felony;

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

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

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

“Cause” for the purposes of suspension shall mean:

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

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.4 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section V.3 hereof;

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

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

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

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

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

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

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

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

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

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the

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

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

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

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

.6 **Return of Materials, Payments of Amounts Due and Settlement of Claims.** If applicable and upon reasonable notice, **DAVIS** may reclaim frame samples at any time during the Term of this Agreement. 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 **PROVIDER** to **DAVIS**. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

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

## VIII DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS** with thirty (30) days advance, written notice to **PROVIDER**. Notwithstanding the foregoing, this Agreement may also be amended by written consent of the Parties hereto.

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

.3 **Modification of Law, Rules, and Regulations**. Notwithstanding anything herein to the contrary, should any pertinent Federal or State law(s), regulation(s), rule(s), directive(s), and/or policies be amended, repealed, or legislated, **DAVIS** shall reserve the right to amend this Agreement without prior notice to or consent from **PROVIDER**. Such amended laws and implementing regulations shall apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without necessitating an execution of written amendments. Nonetheless, **DAVIS** shall employ its best efforts to notify **PROVIDER** of such occurrences, where necessary, within a practicable timeframe.

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

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

.1 **Access to Records**. **PROVIDER** shall make all records related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

(a) **Upon termination** of this Agreement for any reason, **PROVIDER** shall, in a useable form, make available to any Oversight Entities, all records, whether dental/medical or financial, related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.

.2 **Consultation with Provider**. **DAVIS** agrees to consult with **PROVIDER** regarding **DAVIS**' medical policies, quality improvement program and medical management

programs and ensure that practice guidelines and utilization management guidelines:

- (a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
- (b) consider the needs of the enrolled population;
- (c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and
- (d) are communicated to Participating Providers of the Plan(s) and as appropriate to the Members.

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

.3 **Establishment of UR/OM Programs.** Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, in its sole and absolute discretion, and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER**'s rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this paragraph may be deemed by **DAVIS** to be a material breach of this Agreement and may, at **DAVIS**' option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees the decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment for services rendered 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 confirmation of eligibility prior to rendering services.

.4 **Grievance Procedures.** Subject to **PROVIDER**'s rights of appeal, **PROVIDER** shall comply and be bound by the grievance procedure which, in the sole discretion of **DAVIS** and Plan(s) shall be established in accordance with applicable statutes and their implementing regulations for the processing of any patient or **PROVIDER** complaint regarding Covered Services. From time to time, should the grievance procedure require modification whether by **DAVIS** or Plan(s), it shall be modified in accordance with applicable regulations and Section V.3 "Compliance with Davis and Plan Rules" herein.

.5 **Member Grievance Resolution.** **PROVIDER** shall cooperate with **DAVIS** in the investigation of any complaint regarding the materials or services provided by **PROVIDER**. The cost of providing replacement services or materials to satisfy any reasonable Member complaint shall be borne by **PROVIDER** if the grievance is determined to be the result of improper execution of services on the part of **PROVIDER** or if materials are not functioning in the manner prescribed by the Participating Provider(s) and/or the professional staff.

.6 **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.

.7 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**’, MCO’s, and/or Plan(s)’ medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review; care coordination activities including, but not limited to, medical record reviews, HEDIS reporting, disease management programs, case management, clinical practice guidelines, and other quality measurements to improve Members’ care. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization’s activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and Medical Assistance Program Members. **PROVIDER** shall implement a continuous quality improvement action plan if areas for improvement are identified.

## X GENERAL PROVISIONS

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

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

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

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

.5 **Entire Agreement of the Parties**. This Agreement supersedes any and all



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

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

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

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

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

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

.11 **Proprietary Information.** **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Member, including but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all

manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS PROVIDER** shall not disclose or use any Member Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the Term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express prior written permission of **DAVIS**, the Plan in which the Member is enrolled, and the Member.

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

.13 **Third Party Beneficiaries**.

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

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

.14 **Use of Name**. **DAVIS** reserves the right to the control and to the use of its name(s) and all copyright(s), symbol(s), trademark(s) or service mark(s) presently existing or later established. **PROVIDER** shall not use **DAVIS'** or any Plan's name(s), tradename(s), trademark(s), symbol(s), logo(s), or service mark(s) without the prior, written authorization of **DAVIS** or such Plan.

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

*-SIGNATURE PAGE TO FOLLOW-*

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

**PROVIDER:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

Print Date: \_\_\_\_\_

Print All Addresses Below [complete addresses for all practice locations]:

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 3: \_\_\_\_\_

Address 4: \_\_\_\_\_

Address 5: \_\_\_\_\_

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

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

**DAVIS VISION, INC.:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

Date: \_\_\_\_\_

[For DAVIS use only]

**Effective Date:** \_\_\_\_\_

[For DAVIS use only]

Notes: \_\_\_\_\_

[For DAVIS use ONLY]