DAVIS VISION
PROVIDER DOCUMENT REQUIREMENTS
FOR THE STATE OF TEXAS

Davis Vision's provider credentialing policy for network participation requires all applicants/practitioners in the State of Texas to **complete and/or provide all documents listed below**. *No authorization of services for a Davis Vision plan member shall be granted prior to an applicant's satisfactory completion of the credentialing process.

_____________ **APPLICATION**

Texas Standardized Credentialing Application -LHL234/Rev. 0506. [Pages 1-13; Attachments A-H]

_____________ **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF TEXAS**

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

_____________ **W-9 FORM**

_____________ **COPY OF ALL CURRENT STATE REGISTRATIONS**

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

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

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

_____________ **COPY OF CURRICULUM VITAE OR RESUMÉ**

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

_____________ **COPY OF BLANK PATIENT EXAM FORM**

____________________ ***NATIONAL PROVIDER IDENTIFIER (NPI) Number**
(Please Insert NPI # above)

Kindly forward all documentation to: Davis Vision, Inc., 159 Express Street, Plainview, NY 11803 – Attn: Recruiting Department.

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P.O.Box 149104, Austin, Texas 78714-9104
Telephone 512 322-4266 • Fax 512 490-1013 or 512 490-1012 • www.tdi.state.tx.us

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Requirements for completion of any section below may vary with credentialing entity.

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H Additional Work History	as necessary	as necessary

* *In all required sections only provide information based on the last three years or since your last reappointment.*
Reproduction of this form without any changes is allowed.

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)
With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the *Texas Government Code*, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you you have submitted this application.

Texas Standardized Credentialing Application

Please print or type.

Section I–Individual Information

TYPE OF PROFESSIONAL

LAST NAME	FIRST	MIDDLE	(JR., SR., ETC.)

MAIDEN NAME	YEARS ASSOCIATED (YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY)

HOME MAILING ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)

CORRESPONDENCE ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/ YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/ YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/ YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I intend to sit for the Boards on (date).

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

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

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I intend to sit for the Boards on (date).

DO YOU WISH TO BE LISTED IN THE MANAGED CARE DIRECTORY UNDER THIS SPECIALTY?

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

ADDITIONAL SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/ YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/ YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/ YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I intend to sit for the Boards on (date).

DO YOU WISH TO BE LISTED IN THE MANAGED CARE DIRECTORY UNDER THIS SPECIALTY?

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

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Professional Liability Insurance Coverage

SELF-INSURED? ☐ Yes ☐ No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY		
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE $	AMOUNT OF COVERAGE AGGREGATE $	TYPE OF COVERAGE	LENGTH OF TIME WITH CARRIER
NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE $	AMOUNT OF COVERAGE AGGREGATE $	TYPE OF COVERAGE	LENGTH OF TIME WITH CARRIER

Hospital Affiliations–*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☐ No ☐ N/A	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?		
PRIMARY HOSPITAL DO YOU HAVE ADMITTING PRIVILEGES? ☐ Yes ☐ No ☐ N/A			START DATE (MM//YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES?			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

☐ Please check this box and submit Attachment A if you have additional current hospital affiliations.

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES?		AFFILIATION DATES (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

☐ ***Please check this box and submit Attachment B if you have additional previous hospital affiliations.***

Call Coverage

☐ See attached list of hospital staff within my department I utilize for call coverage.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTY.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. 0 CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

Primary Practice Location *Information Please answer the following questions for each practice location.*

TYPE OF SERVICE PROVIDED

☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	
PRACTICE LOCATION ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
BACK OFFICE PHONE NUMBER/PRIVATE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
GROUP NUMBER AND NAME CORRESPONDING TO TAX ID NUMBER (IF APPLICABLE)		
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE MANAGED CARE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER
CREDENTIALING CONTACT		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER / FAX	E-MAIL	
BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE	
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER / FAX	E-MAIL	
DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Day	Morning	Afternoon	Evening
Monday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Tuesday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Wednesday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Thursday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Friday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Saturday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Sunday:	☐ No office hours, or Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?

☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS

☐ All new patients ☐ Existing patients with change of payor ☐ New patients with referral ☐ New Medicare patients ☐ New Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS

☐ Male only ☐ Female only ☐ Age Limitation If yes, Age Range: Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, DENTAL HYGENISTS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?

☐ Yes ☐ No If yes, provide the following information for each staff member:

Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS	NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?

☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?

☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?

☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?

☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?

☐ Bus ☐ Subway ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?	DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No	☐ Yes ☐ No

WHO AT THIS LOCATION HAS THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support:	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB:	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support:	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation:	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support:	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support:	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support:	☐ Staff	☐ Provider Exp:	Other:	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE?

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

☐ X-Ray; please list all certifications:

Other Services:

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Venipuncture
☐ Age appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration/Treatments	☐ Cardiac Stress Tests	☐ Physical therapies

☐ Other: please list any special services, treatment modalities or additional office procedures provided (including surgical procedures)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?

☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ *Please check this box and submit Attachment C if you have additional locations.*

Licenses and Certificates–Please include all license(s) and certifications in all states where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION

IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT?

☐ Yes ☐ No ☐ N/A

DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE?
		☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION

IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT?

☐ Yes ☐ No ☐ N/A

DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE?
		☐ Yes ☐ No
DEA NUMBER	DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
DPS NUMBER	DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)

PRESCRIPTIVE AUTHORIZATION NUMBER (PAN ONLY)		
PROVIDER NUMBERS	UPIN	NPI
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Number:	
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No Number:	ECFMG ISSUE DATE (MM/DD/YYYY)	

☐ *Please check this box and submit Attachment D if you have additional licenses and certificates.*

References

1 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
2 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
3 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

Section II –Disclosure Questions

Please provide an explanation on page 9 for any question answered yes (except questions 12 and 18).

Licensure and Controlled Substances Certificates

1 Has your license or certification to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily or involuntarily surrendered, or have you ever been subject to a consent order, probation, or any conditions or limitations by any state licensing board? ☐ Yes ☐ No

2 Have you ever been reprimanded or fined by any state licensing or certification board? ☐ Yes ☐ No

3 Have any of your Federal DEA or DPS Controlled Substances Certificates or prescriptive authorities ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? ☐ Yes ☐ No

4 Are there currently any pending challenges to any of your state licenses, DEA, prescriptive authority or state controlled substance registrations? ☐ Yes ☐ No

Hospital Privileges and Other Affiliations

5 Have your clinical privileges or professional staff membership at any hospital or health care institution ever been involuntarily terminated, surrendered, limited, reduced, denied, suspended, revoked, restricted, denied renewal, or subjected to probationary or to other disciplinary conditions (for reasons other than automatic action based on non-completion of medical records), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board? ☐ Yes ☐ No

6 Have you voluntarily surrendered or withdrawn an application, limited your privileges, or not reapplied for privileges? ☐ Yes ☐ No

7 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ Yes ☐ No

Education, Training and Board Certification

8	Are you currently or have you ever been placed on probation, under restriction or limitation, disciplined, reprimanded, suspended, terminated, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes	☐ No	
9	Have you ever voluntarily resigned or terminated prematurely your status as a student or employee in an internship, residency, fellowship, preceptorship or other clinical education program while under investigation or in return for not conducting an investigation?	☐ Yes	☐ No	
10	Have any of your board certifications or eligibility for board certification ever been revoked?	☐ Yes	☐ No	
11	Have you ever chosen not to recertify or voluntarily surrendered any of your board certifications while under investigation or in return for not conducting an investigation?	☐ Yes	☐ No	
12	Are you authorized by the Texas Board of Nurse Examiners in the same Advanced Practice Nurse roles and/or specialties for which you seek credentialing (APN only)?	☐ Yes	☐ No	

Medicare, Medicaid or other Governmental Program Participation

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

Other Sanctions or Investigations

14	Are you currently or have you ever been the subject of an investigation by any hospital or health care institution, licensing authority, DEA or DPS authorizing entity, education or training program, Medicare or Medicaid program, or any other private, state or federal health program?	☐ Yes	☐ No	
15	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐ Yes	☐ No	
16	Have you ever been sanctioned or declared an ineligible person by any federal or state regulatory agency (e.g., Office of Inspector General (OIG), Health & Human Services Commission (HHSC), Clinical Laboratory Improvement Amendments (CLIA), Occupational Safety & Health Administration (OSHA), etc.)?	☐ Yes	☐ No	
17	Are you currently or have you ever been investigated, sanctioned, reprimanded or cautioned by a government (e.g.,Depar tment of Defense, Veterans Administration) hospital or facility, or been terminated or asked to resign while under investigation by a government hospital or facility?	☐ Yes	☐ No	

Malpractice Claims History

18	Have any arbitrated, litigated, mediated, pending, dismissed or settled before filing professional malpractice actions, claims or notices of claim ever been filed or submitted against you?	☐ Yes	☐ No	

☐ ***If yes, please check this box and submit Attachment E.***

19	Has your professional liability insurance policy ever been cancelled or renewal refused?	☐ Yes	☐ No	
20	Have limitations ever been placed on the scope of coverage or have you received notice of intent?	☐ Yes	☐ No	

Criminal

21	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	☐ Yes	☐ No	
22	Was this felony reasonably related to your qualifications, competence, functions, or duties as a health care professional?	☐ Yes	☐ No	☐ N/A
23	Did this felony involve an violent or sexual offense against a child, or an elderly or disabled person?	☐ Yes	☐ No	☐ N/A
24	Have you ever been court-martialed for actions related to your duties as a health care professional? (Please check N/A if you have not served in the military)	☐ Yes	☐ No	☐ N/A

Health Status and Ability to Perform Job

25 Are you currently or have you ever been diagnosed with or received treatment for any physical, mental, chemical dependency or emotional condition which could in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty? ☐ Yes ☐ No

26 Are you currently limited by any physical, mental or chemical dependency problem which could in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty now or within the next three years? ☐ Yes ☐ No

Health Status and Ability to Perform Job

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

28 Do you use any chemical substance that would in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty with reasonable skill and safety? ☐ Yes ☐ No

29 Are you currently or have you ever been placed under a monitoring or rehabilitation contract or agreement by any professional society or institution for problems associated with a chemical dependency or emotional condition, or for unprofessional or disruptive behavior? ☐ Yes ☐ No

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

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

32 DATE OF LATEST TUBERCULIN (PPD) TEST (MM/DD/YYYY)	RESULTS	WERE X-RAYS TAKEN?

Please use the space below to explain yes answers to any question except questions 12 and 18.

QUESTION NUMBER	PLEASE EXPLAIN

Section III–Standard Authorization, Attestation and Release *(not for Use for Employment Purposes)*

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as “Participation”) at or with

PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE “ENTITY”)

and any of the Entity’s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a professional staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

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

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

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

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

APPLICANT’S INITIALS AND DATE (MM/DD/ YYYY)

Section III–Standard Authorization, Attestation and Release *(continued)*

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

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process.

For Managed Care Organizations, I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or electronic signature).

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

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

____
SIGNATURE

____
NAME (PLEASE PRINT OR TYPE)

____
SOCIAL SECURITY NUMBER

____
DATE (MM/DD/YYYY)

Required or Supplemental Information-Please attach hard copy or scanned documents of the following:

- ☐ Copy of Current State License (for initial appointment regardless of current licensure status)
- ☐ Copies of DEA or state DPS Controlled Substances Registration Certificates
- ☐ Copy of other Controlled Dangerous Substances (CDS) Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable
- ☐ Copy of ECFMG certifications, if applicable
- ☐ Copies of Board Certification Certificates, if applicable
- ☐ Copies of Training Certificates, if applicable

Section IV–Additional Individual Information

SEX	DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP
☐ Female ☐ Male			

IF NOT AMERICAN CITIZEN/VISA NUMBER	STATUS	ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES ?
☐ Yes ☐ No		

MILITARY SERVICE PUBLIC HEALTH SERVICE	DATES OF SERVICE (MM/DD/YYYY – MM/DD/YYYY)	LAST LOCATION
☐ Yes ☐ No		

BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY?
☐ Yes ☐ No	

Section V–Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)

Issuing Institution:

ADDRESS		
CITY	STATE /COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)

☐ ***Please check this box and submit Attachment F if you have additional professional degrees.***

POST- GRADUATE EDUCATION

☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE /COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR IF KNOWN	

POST- GRADUATE EDUCATION

☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE /COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR IF KNOWN	

☐ ***Please check this box and submit Attachment G if you received additional post -graduate training.***

OTHER GRADUATELEVEL EDUCATION

Issuing Institution:

ADDRESS		
CITY	STATE /COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/ YYYY–MM/ YYYY)	

VI–Work History (please complete the following for a minimum of the previous five years)

CURRENT PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/ YYYY TO MM/ YYYY) IN WORK HISTORY.

Gap Dates:	Explanation:
Gap Dates:	Explanation:
Gap Dates:	Explanation:
Gap Dates:	Explanation:

☐ ***Please check this box and submit Attachment H if you have additional work history.***

Section VII–Continuing Education (CE)

HAVE YOU MET THE MINIMUM REQUIREMENTS FOR RENEWAL OF YOUR LICENSE?

☐ Yes ☐ No Please list below the CE Credits attained during the last two years.

PROGRAM TITLE	ATTENDENCE DATES (MM/ YYYY)	CREDIT HOURS	CATEGORY

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P.O.Box 149104, Austin, Texas 78714-9104
Telephone 512 322-4266 • Fax 512 490-1013 or 512 490-1012 • www.tdi.state.tx.us

Attachment A–Additional Current Hospital Affiliations

OTHER HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES ☐ Yes ☐ No ☐ N/A			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?			

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Attachment B–Additional Previous Hospital Affiliations

PREVIOUS HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES ☐ Yes ☐ No ☐ N/A			AFFLIATION DATES (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE			
PREVIOUS HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE			
PREVIOUS HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES			AFFLIATION DATES (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE			
PREVIOUS HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/ YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (E.G. PROVISIONAL, LIMITED, CONDITIONAL)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE			

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Attachment C–Additional Practice Location Information

TYPE OF SERVICE PROVIDED

☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME		GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	
PRACTICE LOCATION ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
BACK OFFICE PHONE NUMBER/PRIVATE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER	
GROUP NUMBER AND NAME CORRESPONDING TO TAX ID NUMBER (IF APPLICABLE)			
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/ YYYY)	DO YOU WANTTHIS LOCATION LISTED IN THE MANAGED CARE DIRECTORY? ☐ Yes ☐ No	
OFFICE MANAGER OR STAFF CONTACT		PHONE NUMBER	FAX NUMBER
CREDENTIALING CONTACT			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
BILLING COMPANY'S NAME (IF APPLICABLE)		BILLING REPRESENTATIVE	
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
DEPARTMENT NAME IF HOSPITAL-BASED ☐ Yes ☐ No		CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY?

HOURS PATIENTS ARE SEEN

		Afternoon	Evening
Monday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Tuesday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Wednesday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Thursday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Friday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Saturday:	☐ No office hours, or Morning:	Afternoon:	Evening:
Sunday:	☐ No office hours, or Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?

☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS

☐ All new patients ☐ Existing patients with change of payor ☐ New patients with referral ☐ New Medicare patients ☐ New Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS

☐ Male only ☐ Female only ☐ Age Limitation If yes, Age Range: Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, DENTAL HYGENISTS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?

☐ Yes ☐ No If yes, provide the following information for each staff member:

Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number
Name	Professional Designation	State & License Number

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?

☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?

☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?

☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?

☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?

0 Bus 0 Subway 0 Regional Train 0 Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?

☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?

☐ Yes ☐ No

WHO AT THIS LOCATION HAS THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support:	☐ Staff ☐ Provider Exp:	Advanced Life Support in OB:	☐ Staff ☐ Provider Exp:
Advanced Trauma Life Support:	☐ Staff ☐ Provider Exp:	Cardio-Pulmonary Resuscitation:	☐ Staff ☐ Provider Exp:
Advanced Cardiac Life Support:	☐ Staff ☐ Provider Exp:	Pediatric Advanced Life Support:	☐ Staff ☐ Provider Exp:
Neonatal Advanced Life Support:	☐ Staff ☐ Provider Exp:	Other:	☐ Staff ☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE?

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

☐ X-Ray; please list all certifications:

Other Services:

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Venipuncture
☐ Age appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration/Treatments	☐ Cardiac Stress Tests	☐ Physical therapies

☐ Other: please list any special services, treatment modalities or additional office procedures provided (including surgical procedures)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?

☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P.O.Box 149104, Austin, Texas 78714-9104
Telephone 512 322-4266 • Fax 512 490-1013 or 512 490-1012 • www.tdi.state.tx.us

Attachment D–Additional Licenses and Certificates

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
IS THIS STATE PART OF THE INTERSTATE NURSING LICENSURE COMPACT? ☐ Yes ☐ No ☐ N/A		
DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
PRESCRIPTIVE AUTHORIZATION NUMBER (APN ONLY)		
ADDITIONAL PROVIDER NUMBERS	UPIN	NPI

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Attachment E–Medical Malpractice Claims History

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	NOTICE OF CLAIM GIVEN (MMDD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER		AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $

METHOD OF RESOLUTION

☐ Dismissed ☐ Settled before Filing ☐ Settled (with prejudice) ☐ Settled (without prejudice)
☐ Judgment for Defendant(s) ☐ Judgement for Plaintiff(s) ☐ Mediation or Arbitration

DESCRIPTION OF ALLEGATIONS

WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT

TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?

☐ Yes ☐ No

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	NOTICE OF CLAIM GIVEN (MMDD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER		AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $

METHOD OF RESOLUTION

☐ Dismissed ☐ Settled before Filing ☐ Settled (with prejudice) ☐ Settled (without prejudice)
☐ Judgment for Defendant(s) ☐ Judgement for Plaintiff(s) ☐ Mediation or Arbitration

DESCRIPTION OF ALLEGATIONS

WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT

TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?

☐ Yes ☐ No

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Attachment F–Additional Professional Degrees

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)
PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)
PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)
PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)
PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)
PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/ YYYY)

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Attachment G–Additional Post-Graduate Training

POST- GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY–MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	

POST- GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY–MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	

POST- GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY–MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	

POST- GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment Specialty:

INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/ YYYY–MM/ YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P.O.Box 149104, Austin, Texas 78714-9104
Telephone 512 322-4266 • Fax 512 490-1013 or 512 490-1012 • www.tdi.state.tx.us

Attachment H–Additional Work History

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/ YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/ YYYY TO MM/ YYYY) IN WORK HISTORY.

Gap Dates:	Explanation:
Gap Dates:	Explanation:
Gap Dates:	Explanation:
Gap Dates:	Explanation:
Gap Dates:	Explanation:

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

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

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

or

Employer identification number

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

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

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

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

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

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

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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

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

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

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

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

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

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

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

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

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

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

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

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

Exempt From Backup Withholding

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

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

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

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

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

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

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

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

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

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

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

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

10. A real estate investment trust,

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

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

13. A financial institution,

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

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

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

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

Privacy Act Notice

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

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

PROVIDER PARTNERSHIP PROGRAM

Be rewarded for participating in this exclusive partnership program . . .

Provider Benefits include:
- Additional professional fee

Select from the following qualifying designer brands offered by Viva

GUESS eyewear | TOMMY HILFIGER EYEWEAR | GANT EYEWEAR | HARLEY-DAVIDSON PERFORMANCE EYEWEAR | FURLA | ETRO Vision** | Ermenegildo Zegna EYEWEAR** | Magic Clip MAGNETIC EYEWEAR | PURE™ EYEWEAR** | Candie's eyes | magic twist™** | ESCADA | GIVENCHY**

**Available in Select Markets

THE PROVIDER PARTNERSHIP PROGRAM OFFERS THREE LEVELS OF PARTICIPATION BASED ON BOARD SPACE COMMITMENT.

- Davis Vision participating provider may qualify to earn an **extra $5 for each submitted Davis Vision encounter up to $3,000 during contract year.**
- Davis Vision will provide an additional **$5 for each qualifying Viva frame dispensed to Davis Vision members with no annual limit.**
- Davis Vision provider commitment ranges from 100 to 200 units of qualifying designer brands offered by Viva throughout term of agreement.

PROVIDER PARTNERSHIP PROGRAM

Please check the box below if you are interested in receiving more information about the Provider Partnership Program and a Viva Sales Consultant will contact you.

❑ Yes, I am interested in receiving more information about the Provider Partnership Program.

Please return this form to:
Davis Vision, Attn: Provider Recruitment
159 Express Street, PO Box 9104, Plainview, NY 11803

To learn more about the Provider Partnership Program today, contact Jaime Johansen at Viva International, 1-800-245-8482 x5324.

For Davis Vision Use Only
Davis Provider Number ____________________

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

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF TEXAS** (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, **Health Care Service Corporation, a Mutual Legal Reserve Company**, (hereinafter "**HCSC**") having its principal place of business located at 300 East Randolph, Chicago, Illinois 60601 and **PARTICIPATING PROVIDER** (hereinafter "**PROVIDER"**) as defined herein below.

RECITALS

WHEREAS, **DAVIS** has entered into or intends to enter into agreements (hereinafter "Plan Contract(s)") with health maintenance organizations and other purchasers of vision care services (hereinafter "Plan(s)"); and

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

WHEREAS, **HCSC** is a party to this Agreement only with respect to the provision of vision care services by **PROVIDER** to Members in health maintenance organization Plans; and

WHEREAS, **DAVIS** is authorized to act as contracting agent for **HCSC** to contract with **PROVIDER** for the provision of Covered Services to Members in health maintenance organization Plans; and

WHEREAS, the parties desire to enter into this Agreement whereby **PROVIDER** (upon satisfying all Network participation criteria) agrees 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 know as the Health Care Financing Administration (HFCA) or any successor agency.

.2 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a valid authorization number, referencing Member and Member information; (b) a valid, **DAVIS-**assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an

indication as to whether or not dilation was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member.

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

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

.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 "**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.

.8 "**Medical Necessity**" **/** "**Medically Necessary Services**." With respect to the Medical Assistance Program (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.

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

(a) The Covered Service is required in order to diagnose or treat the Member's medical condition (the convenience of the Member, the Member's family or the Participating Provider is not a factor to be considered in this determination); and

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;
(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and
(iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

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

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

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

as likely to produce equivalent therapeutic and/or diagnostic results as to the Member's illness, injury, or disease.

.11 "**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.

.12 "**Medicare Advantage Member**" means a Member who is enrolled in and covered under a Medicare Advantage Program.

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

.14 "**Member**" means an individual and the eligible dependents of such an individual who are enrolled in or who have entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services. Eligible dependents of Members typically include spouses, minor children, and adult children who are full-time students.

.15 "**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).

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

.17 "**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**, 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).

.18 "**Plans**" 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** or **HCSC**.

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

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

.21 "**State**" means the state in which **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders services to a member and/or the State of Texas.

.22 "**Texas Administrative Code**" (hereinafter "TAC") means Title 28 Insurance, Part 1 Texas Department of Insurance, Chapter 11 Health Maintenance Organizations and its subchapters.

.23 "**Texas Health and Human Services Commission**" (hereinafter "HHSC") means the entity with oversight responsibilities for designated Health and Human Services agencies, and which administers certain health and human services programs in the State of Texas, including the Texas Medicaid Program and the Children's Health Insurance Program (CHIP).

.24 "**Texas Health Maintenance Organization Act** (hereinafter "TX HMO Act")" means the Texas Insurance Code (hereinafter "TIC") codified at Chapters 20A and 843.

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

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

III
SERVICES TO BE PERFORMED BY THE PROVIDER

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

(a) **PROVIDER** agrees that the frame collection will be shown to all Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was delivered less any normal deterioration.
(d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.
(e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and at any other time upon reasonable notice. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.
(f) 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 preclude **PROVIDER** from engaging in open clinical dialogue with Members, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** or **HCSC** benefit plan designs.

.3 **Services**. **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO.

.4 **Scope of Practice**. The parties hereto agree and acknowledge that they shall comply with the TX HMO Act §843.363(a)(b) and (c) and that nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

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

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

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

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

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

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

IV
COMPENSATION

.1 **Coding Guidelines and Fee Schedules**. Pursuant to the TX HMO Act §843.321; **DAVIS** shall ensure that **PROVIDER** has access, within thirty (30) days of a **PROVIDER**'s request, to a description and copy of the coding guidelines including any underlying bundling, recoding, or other payment process and fee schedules applicable to **PROVIDER**. Further, **DAVIS** shall ensure that **PROVIDER** is given notice of changes in coding guidelines or fee schedules that are applicable to **PROVIDER**, at least ninety (90) days prior to the effective date of the change(s), unless such change(s) is required by statute or regulation within a shorter timeframe. **DAVIS** will not retroactively make changes to coding guidelines or fee schedules. **PROVIDER** may terminate his/her/its participation hereunder, on or before the thirtieth (30th) day after the **PROVIDER** receives information under this Section IV.1, and in accordance with the termination provisions contained herein, without penalty or discrimination in other vision care benefit Plans hereunder.

(a) A **PROVIDER** who receives information under Section IV.1 may only (i) use or disclose the information for the purpose of practice management, billing activities, and other business operations, or

(ii) use or disclose the information to a governmental agency involved in the regulation of health care or insurance.

.2 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts set forth in **Exhibit 1** attached hereto, less any Copayment and Deductible collected or to be collected from the Member by the **PROVIDER**. 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.

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

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

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

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

(d) To the extent permitted by law, **PROVIDER** shall provide a courtesy discount of twenty percent (20%) off **PROVIDER'**s usual and customary fees to Members 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 that **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit plan, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation from Members, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit program. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement regardless of the reason for termination, shall be

construed to be for the benefit of the Member(s) and shall not be changed without the approval of appropriate regulatory authorities.

.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 least restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Deductible collected or to be collected from the Member. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within ninety-five (95) days following the provision of Covered Services, submit to **DAVIS** an invoice. (Such invoice may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**). When applicable, and pursuant to Article 21.52Z of the TIC and §21.3701 of Subchapter CC of the TAC, **PROVIDER** shall comply with requirements pertaining to electronic claims filing and **DAVIS** shall comply with all requirements pertaining to the waiver thereof. Failure of **PROVIDER** to submit said invoice within ninety-five (95) days of service delivery will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, erroneous claim payments or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement. Notwithstanding anything herein to the contrary, and pursuant to TX HMO Act §843.323, **DAVIS** shall not refuse to process or to pay an electronically submitted Clean Claim because **PROVIDER** submits the claim in or with a batch submission that includes a claim that does not satisfy the definition of a Clean Claim as defined herein.

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

V
OBLIGATIONS OF PROVIDER

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

.1.1 any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and

.1.2 any information necessary for Plan(s) to administer and evaluate program(s); and

.1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

.1.4 any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies; and

.1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 C.F.R. § 422.516 and all other sections of 42

C.F.R. § 422 relevant to reporting obligations.

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

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

.3 **Compliance with Law and Ethical Standards**. During the term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable Federal, state or municipal statutes or ordinances, all applicable rules and regulations, and the ethical standards of the appropriate professional society. If at any time during the term of this Agreement, **PROVIDER's** license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall timely notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and Federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS Rules**. **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS** including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

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

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

(c) **PROVIDER** acknowledges and agrees that in relation to the provision of Covered Services to Medicare Advantage Members and Plan(s) hereunder, **PROVIDER**, and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare Advantage credentialing requirements. **PROVIDER** acknowledges and understands that the Medicare Advantage Plan is ultimately responsible to CMS for performance of such services; such services shall be monitored by the Plan(s); and the Plan(s) retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s).

.5 **Confidentiality of Member Information**. **PROVIDER** shall be bound by the same standards of confidentiality which apply to the MAP and the State, including unauthorized uses of or disclosures of personal health information.

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

(b) Neither **DAVIS** nor **HCSC** nor **PROVIDER** shall share confidential information with any Member(s)' employer, absent the Member(s)' written consent for such disclosure. **PROVIDER** agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with **DAVIS** in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

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

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

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees that he/she/it shall be duly licensed by the state in which services are to be rendered and that he/she/it shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE). Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS** and Plan(s). Such documentation may include proof of: licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees that **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole

option, the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees that at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall promptly notify **DAVIS** in the event that **PROVIDER** suffers a suspension or termination of his/her/its license or of his/her/its professional liability insurance coverage. **PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s). **PROVIDER** shall use his/her/its best efforts to ensure that vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices. **PROVIDER** agrees to abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services. Notwithstanding anything herein to the contrary, **DAVIS** and **HCSC** shall comply with the TX HMO Act §843.304 prohibiting the exclusion of a practitioner from Network participation based solely upon the type of license or authorization held by the practitioner.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, the DHHS, the HHSC, the MAP, or other appropriate external review organization or regulatory agency ("Oversight Entities") **PROVIDER** shall make available all administrative, financial, medical, and all other records that relate to the delivery of items or services under this Agreement. **PROVIDER** shall provide all such access to the aforementioned records at no cost to **DAVIS** and/or to the requesting Oversight Entity, and in the form and format requested. **PROVIDER** shall allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity. **PROVIDER** shall permit and/or make available to the HHSC Office of the Inspector General and/or the Texas Medicaid Fraud Control Unit, its employees, agents, (sub)contractors, and patients, for private, in–person interviews, or for consultations, jury proceedings, pre-trial conferences, hearings, trials and such other processes as may be necessary to conduct such Oversight Entity's investigation. **PROVIDER** understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the Texas State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. **PROVIDER** agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. **PROVIDER** further understands and agrees that he/she/it is bound to report any suspected fraud or abuse, including any suspected fraud and abuse committed by the Plan or a Member, to the HHSC Office of the Inspector General. **PROVIDER**'s obligations contained herein shall survive termination of this Agreement.

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

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

(b) **PROVIDER** agrees to provide **DAVIS** with ninety (90) days notice, or such notice as is reasonably possible, if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/its office location, or (c) be reducing capacity at an office location. Under no circumstance shall provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER, DAVIS,** and **HCSC**.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, **HCSC**, 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**, **HCSC**, 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.

.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.

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s)s covered under one or more of the Plans or in conflict with the terms of this Agreement. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84), The Age Discrimination Act of 1975 (45 CFR 91), The Rehabilitation Act of 1973, The Americans with Disabilities Act of 1990, and Title 40 of the Texas Administrative Code, chapter 73; **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status, need for services, or method of payment; and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR 438.206(c)(2), **PROVIDER** and Participating Provider(s) agree that Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Further, **PROVIDER** understands that payments for Covered Services hereunder may, in whole or in part, be from Federal funds and that **PROVIDER** is subject to applicable laws related to the receipt of Federal funds, including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"). During the term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

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

.15 **Participation Criteria**. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of his/her/its employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a Federal health care program as described in Section 1128B(f) of the Social Security Act, and that all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current Universal Provider Identification Number and/or National Provider Identifier.

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

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

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

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

(a) Pursuant to 42 CFR 422.504 and in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to maintain and safeguard contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agrees to provide such information to **DAVIS,** to contracting Plans, to applicable state and Federal regulatory agencies, including but not limited to the DHHS, the Office of the

Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

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

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

.18 **Subcontractors**. **PROVIDER** agrees that if **PROVIDER** enters into subcontracts or lease arrangements to render any health/vision care services that are permitted under the terms of this Agreement, **PROVIDER**'s subcontracts or lease arrangements shall include the following:

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

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

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

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

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

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

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

VI

TERM OF THE AGREEMENT

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

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

VII
TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause**. After the initial twelve (12) month term has ended, this Agreement may be terminated by **DAVIS** or **PROVIDER** 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, **DAVIS** shall comply with all applicable provisions of the TX HMO Act §843.306, and **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 and in accordance with §843.306.

.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;

(e) a conviction of a felony;

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

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

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

“Cause” for the purposes of suspension shall mean:

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

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

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

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

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

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

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

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

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

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

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

.4 **Responsibility for Members at Termination**. In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement for a minimum transitional period of ninety (90) days, 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 Medically Appropriate, Covered Services provided to a Member pursuant to this Section VII.4 (prior to and following the effective termination date of this Agreement) at the rates for Covered

Services indicated in **Exhibit 1** of this Agreement. Any dispute arising from this Section VII.4 shall be resolved in accordance with the then current **DAVIS** Vision Care Plan Provider Manual.

(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, with accrediting standards, or with TX HMO Act §843.362 regarding Member(s) who have a "special circumstance" and in accordance with the dictates of medical prudence. For the purposes of this Section VII.4, "special circumstance" means a condition regarding which a **PROVIDER** reasonably believes that discontinuing care would cause harm to a Member/patient. Examples of a Member who has a "special circumstance" include, but are not limited to, a Member with a disability, acute condition, life-threatening illness, or who is past the twenty-fourth (24th) week of pregnancy. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

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

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

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

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

.7 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to provide said Member(s) with reasonable advance notice prior to the effective date of such action or termination.

VIII
DOCUMENTATION AND AMENDMENT

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

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

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

.4 **Modification of Claims Payment Procedures**. Notwithstanding the foregoing, and pursuant to the TIC Chapters 843 and 20A, **DAVIS** shall provide **PROVIDER** with a ninety (90) calendar day written, notice should any claims payment procedures, or addenda, schedules, or policies submitted by or on behalf of **PROVIDER** and used by **DAVIS** in carrying out payment of claims hereunder, be amended, revised or substituted. Such ninety (90) day notice period may be shortened when required by statute or regulation.

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

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

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

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

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

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

reviewed and updated periodically; and

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

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

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

(a) In compliance with TX HMO Act §843.283, **PROVIDER** acknowledges and agrees that **PROVIDER** is required, in all **PROVIDER** locations which participate in the **DAVIS** Network, to post information giving notice to Member(s) of the process for resolving complaints against the MCO. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing a complaint.

(b) In compliance with the TX HMO Act §843.281, **DAVIS** shall not engage in any retaliatory action, including the refusal to renew or the termination of **PROVIDER**'s Participating Provider Agreement, because **PROVIDER** reasonably files a grievance or a complaint against **DAVIS** or MCO, or appeals a decision of **DAVIS** or MCO on behalf of a Member.

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

.6 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and MA Program Members.

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 their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** may not assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of **DAVIS**.

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

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

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

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

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

.8 **Non-Solicitation of Members**. During the term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Members, Plans or any employer of said Members without **DAVIS'** prior written consent. For purposes of this Agreement, a solicitation shall mean any action by **PROVIDER** which **DAVIS** may reasonably interpret to be designed to persuade or encourage (i) a Member or Plan to discontinue his/her/its relationship with **DAVIS** or **HCSC** or (ii) a Member or an employer of any Member to disenroll from a Plan contracting with **DAVIS** or **HCSC**. A breach of this Section X.8 shall be grounds for immediate termination of this Agreement.

.9 **Notices**. Should either party be required or permitted to give notice to the other party hereunder, such notice shall be given in writing and shall be delivered personally or by first class mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing in the introductory paragraph on the first page of this Agreement. Either party hereunder may change its address by providing written notice in accordance with this Section X.9.

.10 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** or **HCSC** 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** or **HCSC** Plan agreements and the information contained therein regarding **DAVIS**, **HCSC**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or **HCSC** or any Plan and **DAVIS** or **HCSC**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS** or **HCSC**. **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**, **HCSC**, the Plan in which the Member is enrolled, and the Member.

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

.12 **Third Party Beneficiaries**.

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

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

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

.14 **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.

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

DAVIS VISION, INC.:

Signature: ______________________________
Print Name: ______________________________
Print Title: ______________________________
Effective Date: ______________________________
[For DAVIS use ONLY]

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY:

By: Davis Vision, Inc. as Contracting Agent for HSCS in connection with the provision of Covered Services by **PROVIDER** to participate in health maintenance organization Plans

Signature: ______________________________
Print Name: ______________________________
Print Title: ______________________________
Print Date: ______________________________

PROVIDER:

Signature: ______________________________
Print Name: ______________________________
Print Title: ______________________________
Print Date: ______________________________
Print Address (**PROVIDER's complete location address**): ______________________________

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

***** Submission of a completed Texas Standardized Credentialing Application and/or submission of a signed Participating Provider Agreement for the State of Texas does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's completed Texas Standardized Credentialing Application and on the execution by practitioner of the Participating Provider Agreement for the State of Texas 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.

Notes: ______________________________
[**For Davis Vision use ONLY**]

EXHIBIT 1

FEE SCHEDULE

EXHIBIT 1

COMPENSATION

PROFESSIONAL FEES*

*Fees listed below are sample fees for illustrative purposes only and do not reflect fees for all plans. Most plans currently reimburse at $45.00, net of Co-payment, for routine eye exam. All plan fees are considered reimbursement in full, whether fees are reimbursed entirely by Davis Vision or reimbursed in part by Davis Vision and in part by Member Co-payment.

Eye Examination** Ranges from $35.00 - $50.00
(**Including dilated fundus examination when professionally indicated.)

Eyeglass Dispensing Fee+ Ranges from $15.00 - $30.00
(+For a complete pair of eyeglasses selected from the Davis Vision Tower Collection and fabricated through a Davis Vision laboratory.)

Contact Lens Fitting Fee^ Ranges from $50.00 - $85.00
(^When contact lenses are supplied by Davis Vision – i.e. plan contact lenses are daily wear soft & disposable/planned replacement. Non-plan contact lenses are supplied by the Provider's usual source.)

EXHIBIT 1 - COMPENSATION
FEE SCHEDULE FOR INDICATED DAVIS VISION PLANS

	HYBRID AFFINITY PROGRAM
Spectacle Examination*+ **Includes Dilation, when professionally indicated*	$40.00 - $50.00
PAID BY PATIENT	
Frame	
Priced up to $70.00 retail	$40.00
Priced above $70.00 retail	$40.00 plus 10% off the Amt. over $70.00
Spectacle Lenses	
Single Vision	$35.00
Bifocal	$55.00
Trifocal	$65.00
Lenticular	$110.00
Contact Lenses (in lieu of eyeglasses)	
Conventional	20% off U & C
Disposable/Planned replacement	10% off U & C
Glass Lenses	$18.00
Solid Tint	$10.00
Gradient tint	$12.00
Supershield™ (scratch protective) coating on plastic lenses	
Single Vision	$20.00
Multifocal	$20.00
Ultraviolet coating	$15.00
PGX® (sun sensitive) glass lenses	$35.00
Blended invisible bifocals	$20.00
Progressive addition lenses	
Standard Types	$75.00
Premium Types	$125.00
Anti-reflective coating	
Standard Types	$45.00
Polycarbonate lenses	$30.00
Polarized	$75.00
High index (thinner and lighter)	$55.00
Plastic photosensitive lenses	
Single Vision	$65.00
Multifocal	$65.00
Intermediate Vision Lenses	$30.00
OTHER	
Non prescription sunglasses	20% off U & C
Ancillary products/solutions	10% off U & C

+ Fees shown are sample fees for illustrative purposes only and do not reflect fees for all plans. Most plans currently reimburse at $45.00, net of Co-payment, for routine eye exam. All plan fees are considered reimbursement in full, whether fees are reimbursed entirely by Davis Vision or reimbursed in part by Member Co-payment.

All prices illustrated are inclusive of any applicable member copayments
One (1) year warranty required on all plan supplied eyeglasses.