



Dear Eye Care Professional:

We are pleased to offer you and your practice the opportunity to provide quality eye care services to eligible Members, covered by OptiCare Vision Plans (OptiCare), in your area! As such, we have enclosed the Provider Participation Agreement Fee Schedule and additional required documents for your review and consideration.

Upon your decision to participate with OptiCare you will need to complete and submit the following to the Network Management Department at fax number (800) 980-4002.:

- Provider Participation Agreement (PPA)
- Address Information Form
- W-9 Form

OptiCare requires the receipt of all completed forms before issuing your effective date. Please contact the Network Management Department at (800) 531-2818 should you have questions regarding this process or the enclosed documents.

We look forward to working with you and your staff while providing quality eye care services to Members in your area!

Sincerely,

Provider Affairs



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# Return Fax Sheet

To: Network Management From: \_\_\_\_\_

Fax: (800) 980-4002 Pages: \_\_\_\_\_, including cover

Phone: (800) 531-2818

**RE: OptiCare Vision Plans Contract Materials**

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Please process my request for participation with OptiCare.

As instructed, I have completed the below documents and am sending them to you to begin the process.

Required Documents:

- Signed and Dated Provider Participation Agreement Fee Schedule
- Address Information Form
- W-9 Form

Should you have any additional questions or need additional information to complete this process, please contact \_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_.



This Provider Participation Agreement ("Agreement") is the contract between OptiCare Managed Vision, Inc. (referred to in this Agreement as "OptiCare, We, Us, or Our"), on behalf of itself and/or its affiliates, and Provider, an individual licensed to provide (or legal entity whose members are licensed to provide) optometric, ophthalmologic, or other vision care services or supplies (referred to in this Agreement as "Provider, You or Your").

You represent to be:  a sole proprietor;  a duly organized professional organization or other corporate entity;  a partnership; or  other entity (specify) \_\_\_\_\_. If You are a duly organized professional organization or other corporate entity, a partnership, or other entity (as specified), a listing of the individuals associated with this Agreement must be provided to Us with submission of this Agreement. You affirm that You are duly organized, validly existing and in good standing under the laws of the state where You render Covered Services. The person signing on Your behalf affirms that she or he has full power and authority to enter into this Agreement on behalf of You and each individual practitioner or other person or persons who shall be bound by such signature.

This Agreement is entered into by and between the undersigned parties:

**PROVIDER**

Contact Information to be used for giving notice under the Agreement:

Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Street: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office E-mail: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

**OPTICARE**

Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Street: 112 Zebulon Court  
City: Rocky Mount  
State: NC Zip: 27804  
Office E-mail: networkmanagement@opticare.net

This Agreement is effective on \_\_\_\_\_ (as designated by Us).

Execution constitutes agreement to the attached terms of this Agreement and the following Exhibits:

- Exhibit A-1: OptiCare Vision Plans
- Exhibit A-2: OptiCare Discount Plan
- Exhibit B: Definitions

## THE PARTIES AGREE TO THE FOLLOWING:

### I. Your Responsibilities

- A. You agree to provide Covered Services to Members in accordance with this Agreement, any current or future Amendments, Attachments Exhibits, and the OptiCare Provider Manual ("Provider Manual").
- B. You represent and warrant that: You are fully licensed to practice medicine, optometry, or to provide optical services; are board eligible or certified in the medical specialty of ophthalmology, if applicable; are in good professional standing to provide Covered Services to Members; You have and will maintain a current, valid Drug Enforcement Administrative registration number and unrestricted prescription privileges, if applicable; and You, if applicable, are a member in good standing with admitting privileges with a hospital that is a Participating Provider.
- C. You agree that You have and will keep in effect professional liability insurance of at least \$1 million per occurrence and \$3 million aggregate, or such other general and professional liability insurance as required by state law or as mutually agreed to by You and Us.
- D. If You are a separate legal entity, rather than an individual, You represent and warrant that You shall remain fully licensed and in good standing to do business and provide Covered Services and all of Your agents and employees meet the obligations of this Agreement, where applicable.
- E. You agree to maintain where credentialing is required at all times, licensure, accreditation, and credentials sufficient to meet Our credentialing verification program requirements, which includes those items listed within any applicable state or federal credentialing applications or Our credentialing application, and to notify Us promptly of any changes to any information relating to Your professional credentials during the term of this Agreement.
- F. You agree to make every reasonable effort to notify Us within three (3) days of the occurrence of any disciplinary proceedings of sufficient gravity to be reported to or initiated by the applicable state licensing board or state board of examiners of any state in which proceedings may be brought against You, or any other similar regulatory authority.
- G. You agree to accept as payment in full the compensation described in Exhibit A(s) of this Agreement for Covered Services provided by You to a Member. The remainder of this paragraph is not applicable to Members enrolled in Self-Insured Plans. In no event, including but not limited to Our insolvency or breach of this Agreement, shall You bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or other persons acting on Members' behalf for Covered Services provided pursuant to this Agreement. This provision shall not, of course, prohibit You from collecting from Members (a) Copayments, Coinsurance and applicable Deductibles specified in the applicable Plan, or (b) fees for non-covered services delivered at a Member's specific request, as long as You have notified the Member in advance in writing that the Plan will not cover the requested services and the Member chooses to receive the service at their own expense. This provision shall survive the termination or expiration of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the Member. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Member or person acting on the Member's behalf. Any modification, addition or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the Department of Insurance and, if applicable, the Centers for Medicare and Medicaid Services (CMS), have given written approval for the proposed changes.
- H. You are entitled to bill and have the responsibility for collecting from Members all Copayments, Coinsurance, or Deductibles applicable to Covered Services provided to Members according to the applicable Plan.
- I. You agree not to discriminate against Members on the basis of race, color, national origin, gender, age, religion, marital or health status, health insurance coverage, or other source of payment. As part of this requirement, Your office must be accessible to the disabled, or must have in place reasonable arrangements to accommodate disabled Members.

- K. You agree to all policies and procedures set forth in the OptiCare Managed Vision Provider Manual ("Provider Manual"), which is incorporated into this Agreement by reference. We may unilaterally modify, amend, or update the Provider Manual from time to time, or as required by state or federal law, and any such changes are incorporated into this Agreement by reference.
- L. You agree to cooperate with and participate in any quality management program and procedures, utilization management, member grievance, provider credentialing and network management, and other medical management programs and procedures established by Us or a Payor.
- M. You agree to use best efforts to refer Members to Plan's Participating Providers. You also agree to provide Covered Services in accordance with the availability and accessibility standards outlined in Our Provider Manual.

## II. Our Responsibilities

- A. We agree to pay You for Covered Services provided to Members based on the applicable Provider Fee Schedule attached to this Agreement as Exhibit(s) A or Amendments to this Agreement. We agree to pay claims within any state required claims payment timeframes, as applicable, and in accordance with Our claims payment policies and procedures as described in the Provider Manual. Completed claims payable under a Self-Insured Plan may be paid from funds provided by the Payor in which the applicable Member is enrolled. In the event the Payor fails to make adequate funds available to Us for purposes of issuing payment on such claims, You shall have no recourse against Us and shall look solely to Payor for such payment owed.
- B. We agree to list You as a Participating Provider in applicable Plan provider directories. You authorize Us to use Your name and address in such materials.
- C. We agree to furnish You with password protected access to Our secure website, allowing access to the Provider Manual in addition to information regarding, but not limited to, Member eligibility, claims processing, and Our Policies and Procedures, as described in the Provider Manual.
- D. We may rent or lease access to Provider's services under this Agreement to Groups or a designee that has access to this Agreement through an administrative service agreement. We will make available information regarding the parties that have entered into an administrative service agreement with a network access provision via the Internet. As required by the individual Plan, Groups or a designee will provide eligible Members with identification cards that will incorporate Our name and/or logo to You and/or indicate that eligible Members have accessed the Our Provider network using the name(s) identified by Us to You on the explanation of payment or remittance advice. Under such circumstances, You understand that the Group and not Us will be responsible for all applicable administrative services including the liable for claims decisions and payments for the applicable Plan.
- E. We agree to use reasonable efforts to market and actively promote Our Provider network access to services through an administrative service agreement. We may allow Groups to access Your services under this Agreement for any and all Plans. We make no guarantee concerning the number of Members that will be referred to You under this Agreement.
- F. We may enter into an administrative service agreement with a Group or designated third party to outsource any or all of its functions, including but not limited to: claims, credentialing, and applicable administrative services, at our own discretion. To the extent that such an administrative service agreement will require Your performance, assistance, or cooperation. You agree to comply with the applicable obligations under the agreement in accordance with the specifications provided by Us.

### III. Term and Termination

- A. Term. This Agreement begins on the Effective Date and renews automatically from year to year unless otherwise terminated as set forth below.
- B. Termination For Cause. Either party may terminate this Agreement immediately for cause by providing written notice of termination to the other party. Cause for termination includes, but is not limited to, the following: (1) Our failure to maintain all licenses or certifications required under this Agreement; (2) We determine reasonably and in good faith that continuation of the Agreement may adversely affect the quality of services provided or the Members' health or safety; (3) The voluntary or involuntary initiation of insolvency proceedings by Us or other similar bankruptcy proceedings by You; (4) Breach of any material provision of this Agreement by either party; (5) Your failure to maintain all licenses or certifications required to perform Your duties under this Agreement, or to comply with any applicable state or federal laws, regulations, or Our requirements; (6) Any misrepresentation, falsification, or omission of any material information in Your application submitted to Us; (7) Commission of any act or any conduct or allegation of conduct for which Your license or certification may be subject to revocation or suspension, whether or not actually revoked or suspended, or if You are otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over You; and (8) Your failure to maintain all required liability insurance coverage.
- C. Without Cause. Either party may terminate this Agreement at any time without cause upon ninety (90) days prior written notice, or as required by state and federal laws.
- D. Termination of Payor. If a Payor agreement with Us is discontinued for any reason, the termination date of the Payor agreement will automatically apply to the Exhibit A (Provider Fee Schedule) applicable to that Payor. We will make best efforts to provide timely written notification to You of any such Payor agreement termination.
- E. After Termination. Upon termination of this Agreement for any reason, the rights of each party shall terminate. Any such termination, however, shall not release You or Us from obligations under this Agreement arising prior to the effective date of termination. After termination, We and Our designees shall continue to have access to the records maintained by Provider in accordance with this Agreement for a period of at least ten (10) years from the date of the last Covered Services, or as otherwise required by state or federal law. Termination shall not affect the rights, obligations, and liabilities of the parties arising out of the transactions occurring prior to effective date of termination, including payment of claims for dates of service up to termination.

### IV. Dispute Resolution

- A. The parties agree to make reasonable, good faith efforts to resolve all disputes informally in accordance with the Provider Grievance procedures established by Us. If You are not satisfied with any informal resolution, You may request in writing an appeal, which shall be considered by a Grievance Committee in accordance with Our Provider Grievance procedures.
- B. In the event a dispute is not resolved per Section A above, it may be submitted to mandatory, binding arbitration by a single, impartial arbitrator selected by the American Arbitration Association within sixty (60) days of the last attempted resolution or other time frame as required by state law. The arbitration shall be conducted in accordance with the commercial arbitration rules of the American Arbitration Association, and shall be held in a location mutually agreed to by the parties. Each party shall assume its own costs, but shall share the cost of the arbitrator equally. Judgment upon any award rendered by the arbitrator may be entered in any court having jurisdiction. This arbitration provision shall not apply if prohibited or not required by applicable state law.
- C. Any dispute between Company and Provider concerning any amount owing or alleged to be owed under this Agreement shall be resolved between the Company and the Provider. Provider shall not involve the Member in such dispute. Provider may appeal to Company any such payment determination.

## V. Records and Confidentiality

- A. The parties agree that all medical or clinical records of Members shall be treated as confidential and that both shall comply with all applicable federal and state laws and regulations regarding such records.
- B. You agree to maintain for at least ten (10) years, or as may otherwise be required by state or federal law, after the date of services patient records for all services provided to Members in accordance with industry and regulatory standards. Subject to applicable law and regulations, You shall provide Us or Our designee with reasonable access during regular business hours to medical records, books, and other provider records relating to services provided to Members, and shall make all such records as required by law available to any applicable federal or state regulatory authorities in conjunction with its regulation of Our affairs, Member grievances and complaints, quality of care or other similar matters. Provider shall provide copies of any records to Us upon request at no charge.
- C. Proprietary information received by You from Us shall be treated and kept as confidential and, unless otherwise required by law, shall not be disclosed to any person unless authorized in writing by Us. All reimbursement amounts and Plan information shall be strictly treated as confidential.

## VI. General Provisions

- A. Entire Contract. This Agreement, any Exhibits, any current and future Amendments, and the Provider Manual constitute the entire contract between You and Us. We do not require Providers to sign exclusive agreements nor have stipulations in our Agreement which requires You to participate in multiple product lines as a condition of contracting with Us.
- B. Definitions. Definitions of capitalized terms used in this Agreement are contained in Exhibit B.
- C. Provider-Member Communication. We allow for open Provider-Member communication regarding appropriate treatment alternatives and will not penalize You for discussing medically necessary or appropriate care for a Member, including the discussion of services that have been determined to not meet the definition of Covered Services under the benefit Plan.
- D. Member Grievances. You agree to cooperate with Us or Payor, as applicable, in the implementation of Member grievance procedures and assist Us in taking any appropriate corrective actions. You agree to cooperate with Members in all grievance proceedings and to comply with all final determinations made by Us or Payor pursuant to such grievance procedure. You agree to notify Us promptly of any Member grievances known by You.
- E. Assignment and Delegation of Duties. Neither party may assign, delegate, or transfer any duties, rights, or interests under this Agreement without the other party's prior written consent; provided, however, that any reference to Us shall include any successor in interest, and We may assign any or all of Our duties, rights, and interests in whole or in part to an affiliate, and may delegate or transfer any or all of Our duties or obligations under this Agreement if We notify You in writing prior to any such delegation or transfer.
- F. Liability for Defense. Neither party shall be liable for defending, nor for the expense of defending, the other party, or its agents or employees, against any claim, legal action, dispute resolution, or administrative or regulatory proceeding arising out of or related to such other party's actions or omissions or this Agreement.
- G. Independent Contractor. This Agreement is not intended to create, nor shall it be construed to create, any relationship between Us and You other than that of independent persons or entities contracting for the purpose of this Agreement. Neither party nor any of their representatives shall be construed to be the agent, employer, employee, or representative of the other.
- H. Applicable State Law. The validity, enforceability, and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the state where You provide Covered Services to Members.

- I. Amendment. We may amend this Agreement and Attachments by providing prior written notice to You. In the event You object to any Amendment, including an Amended Exhibit A which serves to add a new Plan or Plans, You must notify Us in writing within (30) days following receipt of the Amendment that You do not accept the terms of such Amendment. Notification to Us of Your rejection of any proposed amendment means that the remainder of this Agreement shall remain in force without the proposed Amendment. Notwithstanding the above, We may amend this Agreement to comply with any changes in federal or state law or regulations and will provide You with written notice of any such amendments. Except as provided in this Section, this Agreement shall not be modified or amended except as agreed to in writing by Us and You.
- J. Exhibits. The Exhibits are a part of this Agreement, and shall supersede other parts of the Agreement in the event of a conflict.
- K. Notices. Any notice required by this Agreement shall be in writing and shall be sent by United States mail, first class postage, facsimile (fax), or electronic mail (e-mail) to the parties according to the contact information indicated on page 1 of this Agreement.
- L. Enforceability. The invalidity and unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

## EXHIBIT A

### PROVIDER FEE SCHEDULE

This Attachment sets forth the payment methodology information relating to the reimbursement to be paid to Provider by OptiCare for the provision of Covered Services.

Provider compensation for Covered Services shall be the lesser of (1) eighty percent (80%) of Provider's usual and customary/billed charges, (2) any maximum allowable reimbursement described in Exhibit(s) A, A1, & A2 provided to Provider or (3) OptiCare's Medicare and/or Medicaid rate(s). By the signing of this Agreement Provider has agreed to be a Participating Provider in OptiCare's Plans. Should Provider choose not to participate in any of the individual current or new Plan(s), Provider is required to provide notification to OptiCare (see **VI. General Provisions**, item I.).

Our Fee Schedule(s) may differ from Plan to Plan, and may be modified or amended by Us from time to time in accordance with the procedures described in this Agreement.

**THIS ATTACHMENT IS AN ESSENTIAL PART OF THE AGREEMENT OF THE PARTIES AND MUST BE INCLUDED WITH ANY AND ALL COPIES OF THE AGREEMENT.**

## Exhibit A-1

### OptiCare Vision Plans Fee Schedule

Allowances may be applied towards the purchase of a complete set of glasses (frame & lenses) or contact lenses (including fitting fees) and lens features. Any charges exceeding the Member's Allowance are to be paid by the Member, less a 20% discount.

	<u>Reimbursement<sup>1</sup></u>
<b>Routine Eye Exam</b>	
Ophthalmological Exam (92002, 92012, 92004, 92014):	\$38
Refraction (92015):	\$9
<b>Eyewear<sup>2</sup></b>	
Frame <sup>3</sup> (V2020, V2025):	55% of Members Allowance
Ophthalmic Lenses, pair; Single Vision (V2100-V2109):	\$35
Ophthalmic Lenses, pair; Bifocal (V2200-V2209):	\$55
Ophthalmic Lenses, pair; Trifocal (V2300-V2309):	\$78
Ophthalmic Lenses, pair; Lenticular (V2115, V2121, V2215, V2221, V2315, V2321):	\$90
Contact Lenses (S0500, V2500 – V2599):	75% of U&C <sup>4</sup>
Standard CL Fitting (92310) <sup>5</sup> :	\$38
Complex CL Fitting (S0592) <sup>6</sup> :	\$69

#### Lens Features<sup>4</sup>

All individual lens features should be reported and billed separately using the appropriate HCPCS code(s) in addition to the base lens code(s). Reimbursement will be made by Company and/or Member, dependent upon benefit plan design.

Photochromatic/Transition, pair (V2744):	\$40
Tint – solid or gradient, pair (V2745):	\$15
Anti-Reflective Treatment, pair (V2750):	\$40
UV Treatment, pair (V2755):	\$15
Scratch Resistance, pair (V2760):	\$15
Non-formulary Progressive Lens, pair (V2781):	\$85
Formulary Progressive Lens, pair (V2781):	\$45
High Index, pair (V2782, V2783):	\$50
Polycarbonate, pair (V2784):	\$35
Lens features not listed above:	80% of U&C

#### Medically Indicated Eyewear

Medically Indicated Contact Lenses:	95% of U&C
Medically Indicated Contact Lens Fitting:	85% of U&C

Copay, benefit frequency, allowance, formulary and covered services will vary by group; please refer to the Member ID Card, [www.opticare-ehn.com](http://www.opticare-ehn.com) or contact Customer Relations at (800) 368-4790 for Member benefit and eligibility.

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<sup>1</sup> Usual and Customary (U&C) expenses (Member out-of-pocket applies) over and above the allowance, less a 20% discount, are paid by the Member as an out-of-pocket expense

<sup>2</sup> Member also receives 2<sup>nd</sup> pair discounts (from U&C) of 30% off frames & lenses, 25% off sunglasses, and 20% off additional supply of contact lenses, unless prohibited by manufacturer.

<sup>3</sup> Or equivalent of any non-standard Member allowance

<sup>4</sup> Not to exceed the Member's allowance

<sup>5</sup> Wearers of conventional or disposable lenses. (May be applicable to Contact Lens Allowance or covered in full)

<sup>6</sup> Non-standard wearers (new, toric, RGP, & multifocal). (May be applicable to Contact Lens Allowance or a separate allowed amount for complex lens fittings)

Exhibit A-2

OptiCare Discount Plans

	<u>Charge or Discount<sup>1</sup></u>
Routine Eye Exam (including refraction and/or dilation when appropriate): Eyewear	\$55 or 30% off of U&C, whichever is less
Contact lens evaluations, fittings, and follow-up:	20%
Contact lenses:	20%
Frames and lenses:	25%
Sunglasses:	25%

**Discount Plans:** Specific discount plans may vary but discounts will not exceed those listed on this fee schedule unless amended.

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<sup>1</sup> Unless prohibited by manufacturer

## EXHIBIT B

### DEFINITIONS

The following definitions apply to terms used in this Agreement:

- A. Copayment - the amount indicated in a Plan description, which is due and payable, by a Member directly to You for a Covered Service. Copayments typically are described as a flat dollar amount for each particular type of service or supply.
- B. Coinsurance - the amount indicated in a Plan description, if any, which is due and payable by a Member directly to You for Covered Services, independent of any required Copayments or deductibles. Coinsurance amounts typically are described as a percentage of the rate negotiated between Company and Provider in effect as of the billing date for the provision of Covered Services.
- C. Covered Services - vision care services or supplies for which a Member is entitled to receive benefits under a Plan directly or indirectly provided, administered, or insured in whole or in part by Us.
- D. Deductible - the amount indicated in a Plan description, if any, which must be paid by a Member for Covered Services before Company would assume any liability for all or part of the cost of additional Covered Services. Deductibles typically are described as aggregate dollar amounts and typically apply to all services covered under a Plan during a specific period.
- E. Member - a person (or his or her spouse or other eligible dependents) who is eligible for, and properly enrolled and covered under, a Plan directly or indirectly provided, administered, or insured in whole or in part by Us. Members can include Medicare beneficiaries enrolled in a Medicare product offered as a Plan.
- F. Participating Provider - shall mean a licensed eye care professional, practitioner, or facility, or other related legal entity, that satisfies Our credentialing criteria and has entered into a written agreement with Us to participate in any provider panel established by Us for the provision of Covered Services to Members, and to comply with the reimbursement mechanisms and quality management, utilization management, provider credentialing and network management, grievance, and other procedures established or set forth by Us.
- G. Payor - a managed care organization, such as a PPO or HMO, employer, association, municipality, union, multi-group trust, or other entity which has established a Plan or Plans for the benefit of eligible persons affiliated with the Payor, in which Plan is directly or indirectly provided, administered, or insured in whole or in part by Us (Payor agreement).
- H. Plan - a health care benefits plan financed by or otherwise maintained by a Payor pursuant to which Members receive specified benefits related to Covered Services.
- I. Self-Insured Plan - a Plan that is established, maintained and funded by a Payor and with respect to which We provide administrative services only. We have no financial obligation or financial risk under, and is not considered a fiduciary of, a Self-Insured Plan. We and the Payor offering a Self-Insured Plan have entered into an administrative services agreement under which Payor is solely responsible for funding the payment of claims for Covered Services provided to its Members.



**\*\*INCOMPLETE FORMS MAY DELAY ACCURATE CLAIMS PROCESSING\*\***

**Provider Name:** \_\_\_\_\_ **Title:**  DO  MD  OD  OPT

**Last First MI**

**INDIVIDUAL (TYPE I) NATIONAL PROVIDER IDENTIFIER (NPI):** \_\_\_\_\_

**UPIN:** \_\_\_\_\_ **Medicare:** \_\_\_\_\_ **Medicaid:** \_\_\_\_\_

<b>Indicate if Primary Location:</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Practice Name d/b/a (or directory listing) _____ Address _____ Suite _____ City _____ ST _____ Zip _____ - _____ County _____ Phone: ( _____ ) _____ - _____ Fax: ( _____ ) _____ - _____	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>MEDICAID LOCATION SPECIFIC EXT</b> (Part of ID that identifies each location. TX, PA, GA & IN providers only) _____ Is this a Retail Chain location (or next door to one)? <b>IF YES please name (ie Sears, etc)</b> _____	
Office Hours Sun: - M: - T: - W: - Th: - F: - Sat: -	
<b>Billing:</b> <input type="checkbox"/> <b>Same As Practice Location</b> <input type="checkbox"/> <b>Other (indicate below)</b> Business Name _____ Address _____ City _____ ST _____ Zip _____	<b>Organizational/Billing NPI</b> _____  <b>Tax ID Number</b> <small>(A W-9 must be completed for each unique Tax ID)</small> _____

<b>Indicate if Primary Location:</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Practice Name d/b/a (or directory listing) _____ Address _____ Suite _____ City _____ ST _____ Zip _____ - _____ County _____ Phone: ( _____ ) _____ - _____ Fax: ( _____ ) _____ - _____	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>MEDICAID LOCATION SPECIFIC EXT</b> (Part of ID that identifies each location. TX, PA, GA & IN providers only) _____ Is this a Retail Chain location (or next door to one)? <b>IF YES please name (ie Sears, etc)</b> _____	
Office Hours Sun: - M: - T: - W: - Th: - F: - Sat: -	
<b>Billing:</b> <input type="checkbox"/> <b>Same As Practice Location</b> <input type="checkbox"/> <b>Other (indicate below)</b> Business Name _____ Address _____ City _____ ST _____ Zip _____	<b>Organizational/Billing NPI</b> _____  <b>Tax ID Number</b> <small>(A W-9 must be completed for each unique Tax ID)</small> _____

**\*TO LIST ADDITIONAL OFFICES, PLEASE MAKE APPROPRIATE COPIES.**