Employed Provider Application

November 14, 2025

Provider Application Instructions

1. Please type or print responses using blue or black ink.
2. All questions on the Provider Application must be answered. Incomplete applications (including lack of required documentation) and unsigned agreements will be returned.
3. The following documents and actions must be included with this application or completed prior to submission:
   a. Copy of Current State Licensure(s) in all applicable states
   b. Proof of Current Professional Liability Insurance for any related Provider Business Entity explicitly stating "Professional Liability" or its equivalent identifying per claim and aggregate limits
   c. Copy of W-9 – Request for Taxpayer Identification Number and Certification (for Payee and TIN listed on Page 3) (Separate Provider Application required for each TIN)
   d. Copy of Board Certificates - M.D.s and Doctors of Osteopathy (D.O.s) only, if applicable (Board Certification is not required for network membership)
   e. Update and maintain current Council for Affordable Quality Healthcare (CAQH) and similar state profiles
   f. Authorize Vision Benefits of America, Inc. (VBA) on CAQH
4. Please return the completed Provider Application, along with all required documentation and signed Participating Provider Agreement to VBA by mail, fax, or email, as follows:

If by mail, to:	VBA Attn: Network Operations Department 400 Lydia Street, Suite 300 Carnegie, PA 15106
If by fax, to:	412-885-5646
If by email, to:	network@vbaplans.com

Provider Application Certification

I, the undersigned, a duly licensed Optometrist or Ophthalmologist, in good standing in the state(s) in which I maintain a license to practice, hereby apply to be an in-network provider of services for Vision Benefits of America, Inc. (hereinafter "VBA" or the "Company").

I expressly authorize VBA access to and use of my information appearing within CAQH and similar state profiles.

I certify that the information contained in this Provider Application and within CAQH or similar state profile is true, complete and accurate as of the date hereof.

I acknowledge and understand that the enclosed Participating Provider Agreement lists the rights and obligations I shall have as a provider of services to VBA Members at Provider Business Entity locations if my application is accepted by VBA.

I hereby certify that I have read and understand the Provider Application and VBA Provider Credentialling Policy.

My signature below authorizes all agencies, institutions, healthcare facilities and entities (past, present and future) including all professional liability insurers who have knowledge concerning my qualifications and other information requested in this application to consult with, and release relevant information and records to VBA, its affiliates or representatives. I understand that I have the right to review and correct information obtained during the application process. Upon request, I also have the right to be informed of the status of my credentialing/re-credentialing application.

The following fields are required.

Date: _____ Provider Signature: _____ ☐ OD ☐ MD ☐ DO

Print Provider Name: _____

Provider Application Questionnaire

To expedite the application process and improve data quality, we recommend that you type your information into the form fields below rather than submitting a handwritten application.

Section I. General Provider Information		
First Name:	Last Name:	☐ OD ☐ MD ☐ DO
SSN:	CAQH ID:	DOB:
NPI 1:	Provider Email:	

Section II. Retail Practice Information	
The information requested in this Section II may be filled out below, or, in the alternative, submitted by attaching a separate spreadsheet.	
Primary Retail Practice Payee Name: (As reported on Line 1 of the attached W-9)	**Taxpayer Identification Number (TIN):** (Only one TIN per Application)
Website:	Practice NPI 2:
Payment Selection:	
Taxpayer Identification Number (TIN) is:	
☐ Currently enrolled with VBA. Follow existing payment structure.	
☐ Not enrolled with VBA. Must submit Business Entity Agreement with Provider Application. Payment will be one check per TIN mailed to the Payment Address.	

Payment Address		
Address:		
City:	State:	Zip Code:

Billing/Administrative Contact	Credentialing Contact
Name:	Name:
Phone:	Phone:
Email:	Email:

Section III. Retail Location Information		
Number of locations included in Application:	Additional information attached: ☐ Yes ☐ No	
Primary Retail Location		
Primary Retail Location Doing Business As (DBA):		
☐ Provider Telehealth	Future Start Date:	
Address:		
City:	State:	Zip Code:
County:	Location NPI 2:	
Location Email:		Phone:
Location Website:		Fax:
Location Billing/Administrative Contact	**Credentialing Contact** (If different for each location)	
Name:	Name:	
Phone:	Phone:	
Email:	Email:	
Second Retail Location		
Second Retail Location Doing Business As (DBA):		
☐ Provider Telehealth	Future Start Date:	
Address:		
City:	State:	Zip Code:
County:	Location NPI 2:	
Location Email:		Phone:
Location Website:		Fax:
Location Billing/Administrative Contact	**Credentialing Contact** (If different for each location)	
Name:	Name:	
Phone:	Phone:	
Email:	Email:	

Third Retail Location			
Third Retail Location Doing Business As (DBA):			
	☐ Provider Telehealth	Future Start Date:	
	Address:		
	City:	State:	Zip Code:
	County:	Location NPI 2:	
	Location Email:		Phone:
	Location Website:		Fax:
	Location Billing/Administrative Contact	**Credentialing Contact** (If different for each location)	
	Name:	Name:	
	Phone:	Phone:	
	Email:	Email:	
Fourth Retail Location			
Fourth Retail Location Doing Business As (DBA):			
	☐ Provider Telehealth	Future Start Date:	
	Address:		
	City:	State:	Zip Code:
	County:	Location NPI 2:	
	Location Email:		Phone:
	Location Website:		Fax:
	Location Billing/Administrative Contact	**Credentialing Contact** (If different for each location)	
	Name:	Name:	
	Phone:	Phone:	
	Email:	Email:	
Additional Retail Locations			
☐	See attachment for information on additional retail locations.		

Section IV. Licensure by State

The information requested in this Section III may be filled out below, or, in the alternative, submitted by attaching a separate spreadsheet. The following terms apply to the abbreviated certifications listed below:

CDS = Controlled Dangerous Substances
DPA = Diagnostic Pharmaceutical Agent
DEA = Drug Enforcement Administration
TPA = Therapeutic Pharmaceutical Agent

Primary Licensing State	
Licensing State:	State License #:
TPA/DPA Certified: ☐ Yes ☐ No	
CDS Number:	DEA Number:

If DEA or CDS is not held please complete (REQUIRED):

☐ Not eligible to hold a DEA/CDS in this state.

☐ I do not hold a DEA in this state, Dr. _____ writes prescriptions on my behalf.

☐ I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation.

Second Licensing State	
Licensing State:	State License #:
TPA/DPA Certified: ☐ Yes ☐ No	
CDS Number:	DEA Number:

If DEA or CDS is not held please complete (REQUIRED):

☐ Not eligible to hold a DEA/CDS in this state.

☐ I do not hold a DEA in this state, Dr. _____ writes prescriptions on my behalf.

☐ I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation.

Third Licensing State	
Licensing State:	State License #:
TPA/DPA Certified: ☐ Yes ☐ No	
CDS Number:	DEA Number:

If DEA or CDS is not held please complete (REQUIRED):

☐ Not eligible to hold a DEA/CDS in this state.

☐ I do not hold a DEA in this state, Dr. _____ writes prescriptions on my behalf.

☐ I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation.

Fourth Licensing State	
Licensing State:	State License #:
TPA/DPA Certified: ☐ Yes ☐ No	
CDS Number:	DEA Number:

If DEA or CDS is not held please complete (REQUIRED):

☐ Not eligible to hold a DEA/CDS in this state.

☐ I do not hold a DEA in this state, Dr. _____ writes prescriptions on my behalf.

☐ I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation.

Purpose and Introduction

The purpose of this Vision Benefits of America, Inc. (hereinafter "VBA" or the "Company") policy is to define the process for credentialing of Providers to be accepted in the VBA's Participating Provider Network. Company does not discriminate against any Provider on the basis of race, color, national origin, gender, age, religion, marital status, health status or any other basis under applicable law. All Providers are credentialed according to the standards of the National Committee for Quality Assurance (NCQA). Specifically, this policy sets forth standards and guidelines to accomplish the following:

- Maintain the high quality of the Company network by determining if applicants are in compliance with Company/NCQA standards.
- Review denials with Providers who feel they meet the credentialing standards.
- Provide an appeal process for negative decisions.

Company's Credentialing Committee is responsible for determining which Providers may become Participating Providers. Company maintains a Credentialing Committee comprised of three (3) voting members, including an Optometrist, an Officer of Company, and a Provider Relations Representatives who review all Provider Applications. The decision will be governed by a simple majority vote with each member of the committee having one (1) vote. The committee is empowered to credential any Licensed Ophthalmologist (M.D.), Osteopath (D.O.) and Optometrist (O.D.) if they meet the following parameters, including any additional requirements in the state where the Provider is licensed. Credentialing Committee review and decisions will be completed within sixty (60) days from the receipt of a completed application. All credentialing files that meet the credentialing criteria as clean may be reviewed and approved by a Medical Director per NCQA standards.

Definitions

In addition to the definitions below, any terms defined in the Agreement and appearing in this Schedule C shall have the same meaning given in the within Agreement.

Covered Person: An individual who is covered under the vision program.

Provider: An Ophthalmologist (M.D.), an Osteopath (D.O.) or an Optometrist (O.D.).

The Provider must complete, sign, and date Company's credentials application to be considered for participation in Company's Participating Provider Network. The credentials application includes but is not limited to the following information:

1. Most recent five years of work history as a heath professional with an explanation of any gaps greater than 6 months, if less than five years, timeframe starts at initial licensure date.
2. Attestation to the ability to perform essential functions.
3. Attestation that the provider does not use illegal substances.
4. Attestation to any loss of license since their initial licensure.
5. Attestation to any felony conviction.
6. Attestation of any loss or limitation of privileges or of disciplinary action.
7. Attestation by the applicant of the correctness and completeness of the application.

In addition, the Provider must submit proof of the following:

a. Current, valid license in the state(s) in which Covered Services are provided to Members.

b. Professional liability insurance of at least one million dollars ($1,000,000 USD) per occurrence and three million dollars ($3,000,000 USD) aggregate unless the amount required by the state in which the Provider renders Covered Services to Members provides for other limits, and further that such minimum amounts required shall automatically increase to equal amounts required by the law of the state in which Provider renders said Services. This paragraph does not prohibit insurance amounts that are below the aforesaid minimums, so long as the lower amounts are permissible within, and in accordance with, the laws and regulations of the state in which Provider renders Covered Services pursuant to this Agreement.

   Proof under this paragraph shall be in the form of a current certificate of insurance evidencing coverage in the amounts aforesaid, or otherwise so required, and Provider shall keep such certificate current throughout the existence of this Agreement.

Further, the Provider must complete and sign the attached Provider Agreement with Company. Execution of said Agreement does not constitute Company's acceptance of the Provider as a Company Participating Provider. Final acceptance is contingent upon approval of Company's Credentialing Committee, in accordance with this Credentialing Policy.

Primary Source Verification

Primary Source Verification (PSV) for the Provider credentials listed below will be outsourced to an NCQA accredited Credential Verification Organization (CVO). All primary source verifications are made and documented in accordance with NCQA Standards.

PSV is performed to confirm the following credentials:

1. Current and valid license to practice, in each state where the practitioner is licensed and provides care to Members.
2. If held, current and valid DEA and CDS certification, in each state where the practitioner is licensed and provides care to Members, along with any other state-specific drug qualifications.
3. The highest level of completed training is verified for each practitioner type: Board Certification, residency or graduation from medical or professional school.
4. Proof of valid malpractice insurance with the current coverage dates and amount of coverage.
5. Disciplinary actions, including sanctions, restrictions and limitation on licensure in all states practitioner provides care to members via the National Practitioner Data Bank (NPBD).
6. Malpractice history verified to NPBD. Provider's credentials that reveal the provider has three (3) or more malpractice case settlements with the last five (5) years will be reviewed by the Credentialing Committee prior to approval/denial.

Any information obtained during the credentialing process that varies substantially from the information provided on the application is communicated to the Provider. The Provider will be allotted two (2) weeks to submit the amended information to Company's credentialing department. The corrected information must be provided in writing from the facility or department from which the original information was received (i.e., State License Board, education facility, etc.). Company's Credentialing Department will document the receipt of the corrected information in the Provider's credentials file. Once all information is complete, the Credentialing Department will review and compare all information to established standards and will compare the information on the application

to the primary source data. The completed credentialing files will then be presented to the Credentialing Committee for review and deliberation.

Committee Recommendations

The Credentialing Committee will recommend one of the following actions:

1. The Provider meets all requirements and is recommended for appointment.
2. The Provider needs to provide additional information.
3. The Provider is not recommended for appointment. Specific reasons for denial are described in writing. A letter of denial is sent to Provider.

Confidentiality

All information regarding the credentialing of Providers will be collected and maintained in a confidential manner. Credentialing personnel will be informed of the responsibility to maintain the confidentiality of the information reviewed in the credentials process. All documents, reports, and communications will be filed in a secure area. The minutes of the Credentialing Committee are confidential information not to be discussed with unauthorized personnel.

Re-Credentialing

All providers are re-credentialed every three (3) years. No less than six (6) months prior to the three (3) years, the Credentialing Committee will examine all supporting documentation, credentialing reports, utilization reviews and audits, member complaints and satisfaction surveys to determine which Providers will be re-credentialed. If all of the above are approved by the Credentialing Committee, the Provider Services Agreement stipulates automatic renewal. Any denial of renewal or network membership by the Credentialing Committee that is based upon the professional competence or conduct of the Provider constituting a threat to health, safety or welfare of a Covered Person may be made by written appeal.

Company Denials and Appeals

VBA's Credentialing Committee (VCC) shall have a means of informing a Provider of the denial of an initial or reappointment application for membership in Company. VCC will coordinate an appeals process for providers wanting to appeal negative decisions made by VCC.

Initial Denial Communication

Following a VCC negative decision, that denial will be communicated to the Provider/applicant via certified mail.

Appeals Hearing

Should a Provider request a credentialing denial appeal hearing, VCC's Chairman shall give the Provider notice of the hearing. That notice shall also request Provider's consent to disclose the specifics of his/her application as well as all credentialing documentation to be discussed at an appeals hearing conducted by VCC.

Credentialing Appeals Committee

The voting Committee Members consisting of two Providers (one in the appealing Provider's field of specialization) and a VCC member, all designated by the Chairman of VCC who will also chair the Appeals Committee, shall not be in direct economic competition with the appealing Provider.

Credentialing Appeals Hearing

The Provider has the right to be present at the hearing. The time, date, and place of the hearing will be communicated to the Provider via certified mail at least thirty (30) days in advance of the scheduled hearing.

The Provider may have legal counsel present but must notify VCC Chairman of that intent at least ten (10) business days prior to the hearing. The Credentialing Appeals Committee may arrange for a court reporter to provide a transcript of the hearing. Copies of the reporter's transcript will be provided to the Appeals Committee and Provider upon request.

A VCC representative will submit evidence (oral or written) of the reason for denial. The Provider may call, examine and cross-reference witnesses, and/or present evidence or information to explain or refute the cause of denial. The Appeals Committee has the right to rebut the Provider's evidence and ask either the VCC members of the Provider to clarify any statements or information presented during the hearing.

The VCC and Provider may make summary statements.

The Appeals Committee has the right, at its sole discretion, to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider. The rules of evidence applicable in a court of law do not apply. A party who objects to the presentation of any evidence must state the grounds for the objection, however the Appeals Committee has the sole discretion to determine the evidence that will be admitted.

The Appeals Committee will deliberate without the Provider present and will make its determination based on all the evidence presented and discussed. The decision of the Appeals Committee hearing shall be by majority vote of the members present and be final.

Written notice of the decision will be given to the Provider and will include a written statement of the basis of the decision.

Reporting

When VBA terminates a contract based on a determination of fraud, VBA shall report the fraud, with the basis of the determination of fraud, to the appropriate administrative agencies.

When VBA terminates a contract based on a determination that the Provider represents an imminent danger to the Covered Insured or the public health, safety and welfare, VBA shall report the determination to the appropriate State licensing board.

When a final termination decision has been rendered, VBA shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank (NPDB). The NPDB is a federal agency established pursuant to the Health Care Quality Improvement Act of 1986 that is the repository of information about final adverse actions against practitioners (42 USC § 1320a-7e; 42 USC § 11101).