



Eleven Penn Plaza, New York, NY 10001 • 800-647-2677 • E-mail: Director@MediSaver.com

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March 18, 2002

Dear Optician:

We have customers in your area now! MediSavers is a proven program in the greater metropolitan New York area and is expanding to nationwide scope. MediSavers has been featured in The New York Times, The Wall Street Journal Report, and in over 200 individual newspaper articles, 150 radio reports, and 100 TV stations across the United States.

MediSavers provides for optical, dental, medical and many other services, as well as prescriptions (in accordance with President Bush's plan for affordable healthcare). In an economic recession, consumers tend to defer eye care and glasses. MediSavers overcomes this problem. MediSavers members have no limitations and may utilize all of your services.

Our optical program offers our providers:

- **Simple Procedures for Guaranteed Payment within 10 Days from MediSavers**
- **No Limitations**
- **No Maximums**
- **Confidentiality**
- **No Paperwork**
- **No Membership or Application Fees to the Optician**
- **Free Marketing and Advertising**

You can bring new customers into your business and thereby increase your revenue at no additional cost. MediSavers will market you on the Internet, in our printed directory and mini-directories, media advertising, and direct our Members to your location.

MediSavers only requirement is that you provide our Members a discount from your regular retail charges of:

- |            |     |
|------------|-----|
| 1) 33 1/3% | *   |
| 2) 40%     | **  |
| 3) 50%     | *** |

Remember that when the MediSaver member is choosing an optician, the size of the discount will undoubtedly influence his or her selection. Our directories list optician discounts by 1, 2, or 3 stars. Therefore, the size of the discount you provide will have a direct impact on the volume of MediSavers patients you receive. You may specify if a discount is offered for contact lenses as well.

Our providers say we're their fastest paying program. **DON'T MISS THIS VALUABLE WIN – WIN – WIN OPPORTUNITY!** There is no cost to participate. To join, send in your agreement, including the census form and required documentation, and we'll process them immediately. **Please respond by April 31, 2002 to be included in our next directory.** Call us at 800-647-2677 for more information.

Sincerely,  
**David Konigsberg**  
President

# MediSavers Optician Provider Census Form

This form must be completed by EACH participating provider, and accompanied by appropriate documentation

For Employees and Affiliates please photocopy this form BEFORE entering information

Please TYPE or PRINT complete answers to each item

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## Personal Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Tax I.D. Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Please list other Managed Care programs in which you participate \_\_\_\_\_

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## Billing Information

Billing Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

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## Office Information

Office #1 Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Contact \_\_\_\_\_

Sunday \_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_

Foreign Languages spoken at this office \_\_\_\_\_ E-Mail \_\_\_\_\_

Office #2 Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Contact \_\_\_\_\_

Sunday \_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_

Foreign Languages spoken at this office \_\_\_\_\_ E-Mail \_\_\_\_\_

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We MUST BE INFORMED of any change in the above information. The MediSavers Participating Provider Network is open to ALL providers who meet its selection criteria and are willing to abide by its rules, regardless of race, creed, color, religion or national origin. Providers agree to treat all patients equally without regard to race, creed, color, religion, national origin or source of payment.

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Please Mail Completed Form and required documentation to: MediSavers, Attn: Provider Relations, 11 Penn Plaza, Suite 330, New York, NY 10001  
For Additional Information Call Provider Relations: 800-647-2677  
Fax: 212-629-0749 • E-mail: [Director@Medisaver.com](mailto:Director@Medisaver.com)

## How To Become a MediSavers Provider

1. Fill in this Census Form.
2. Fill in the Provider Agreement and indicate the discount amount of 33 1/3%, 40% or 50%.
3. Sign and date the Provider Agreement at bottom.
4. Enclose a copy of the following documents:
  - a. State License or Registration
  - b. Professional liability insurance coverage
5. Mail completed materials to:

MediSavers  
Attn: Provider Relations  
11 Penn Plaza, Suite 330  
New York, NY 10001
6. If you have any questions please call Provider Relations at 800-647-2677.

OPTICIAN PROVIDER AGREEMENT

This agreement, between MEDISAVERS, and \_\_\_\_\_ ("Provider") sets forth the rights and responsibilities of the parties hereto.

Relationship

MEDISAVERS is a Preferred Provider Organization (PPO), providing access to participating providers to its enrolled membership.

MEDISAVERS and the Provider desire that the Provider become a member of the MediSavers Participating Provider Program for the purpose of providing professional care and treatment to eligible members and dependents of groups serviced by MEDISAVERS. Provider enters into this agreement as an independent contractor and no employer/employee relationship exists or is intended. Provider will at all times maintain the Provider/patient relationship and will be solely responsible for determining and administering the care and treatment of the patient.

Rights and Responsibilities

Both MEDISAVERS and the Provider will be bound by the procedures and requirements herein. These procedures and requirements will remain in effect during the term of this agreement, unless modified in writing, signed by both parties.

The attached census form completed by the Provider is made part of this agreement, and the Provider warrants that all information contained therein is true and complete, and recognizes that MEDISAVERS enters into this agreement in reliance thereon. The Provider will promptly advise MEDISAVERS upon material change in any information .

Reimbursement

All reimbursement for services rendered by the Provider under this agreement will be on a fee for service basis, with a discount of:

33 1/3%

40%

50%

Contact Lens Discount \_\_\_\_\_%

off the provider's customary charges. The discount provided by the Provider to MEDISAVERS will be no less than the discount granted to any other entity or organization.

Fees

The Provider does not pay any fees or dues for participating in this program.

Billing and Payment

Billing and payment will be governed by the rules and guidelines herein. These rules and guidelines will remain in effect during the term of this agreement, unless modified in writing.

Term

This association is purely voluntary, and may be terminated without cause by either party upon ninety (90) days written notice to the other party. The Provider will complete all work and plans of treatment in progress.

\_\_\_\_\_  
Provider

Date\_\_\_\_\_

\_\_\_\_\_  
MediSavers

Date\_\_\_\_\_

## Procedures and Requirements

1. Patients will be referred by MEDISAVERS directly to the Provider, either by a staff member or MEDISAVERS' computerized provider locator system.
2. Should a referral to any other Provider be required, the Provider or patient **must** call MEDISAVERS and specify the type of specialist/Provider required. MEDISAVERS will furnish the patient with a participating Provider. The Provider is **not** to refer the patient directly to another specialist/Provider. If the Provider does so, the Provider will be responsible for ensuring that MEDISAVERS, the patient, the member, and the member's sponsoring group have no more expense than would have been incurred had a participating Provider been used.

## Billing and Payment

1. All fees for services covered by this agreement will be paid by MEDISAVERS', using the clients' monies, directly to the Provider. The Provider understands and agrees that under whatever method or manner he receives payment, payment is not made with MEDISAVERS' own funds, but with funds supplied to it by MEDISAVERS' clients. The Provider understands and agrees that MEDISAVERS is neither a guarantor nor insurer of payment to the Provider and that the Provider must ultimately seek payment from the patient. All disputes wherein claims payments may be withheld must be resolved by the Provider and the patient. If payment is not made by MEDISAVERS and is then sought by the Provider from the patient, the Provider shall be entitled to a fee based upon his/her usual and customary charges from the patient. The Provider will neither seek nor accept payment from the eligible patient or member for any covered service. MEDISAVERS is NOT an insurance company.
2. There is usually no co-payment or cost sharing for covered services rendered to eligible members and dependents of groups participating in MEDISAVERS'. The agreed upon fees will be accepted in full payment by the Provider. If a co-payment is in effect, it will be so indicated on the participant's identification card. If no co-payment is indicated, the Provider will not ask the participant for money. If a co-payment is indicated, the Provider will accept only that amount from the participant.
3. The Provider will file claims electronically, AFTER services have been rendered, via an ordinary touch-tone telephone, follow the computer prompts and enter the information accurately. The system will return an authorization code if the patient is eligible and covered for the services rendered. Payment will be made within ten (10) business days. The Provider must provide the patient with a statement showing the services rendered and the usual and customary fees filed electronically. [It is recommended (but not required) that the Provider submit the claim while the patient is still present in the office.] In the event that a claim is rejected, the Provider may charge the patient at his/her usual and customary fee for services rendered. The Provider may file a paper claim, but there will be no guarantee of payment.
4. In cases where there is other coverage, and that coverage is primary, the Provider **must** bill the other coverage first. If the other coverage pays less than the amount provided under this agreement, then the Provider will be paid the difference between the amount paid by the other coverage and the amount provided under this agreement. Documentation of the first coverage's payment must be submitted to MEDISAVERS along with the claim for co-coordinated benefit payment.
5. In cases where there is other coverage, and that coverage is secondary, MEDISAVERS will pay the amount allowed under this agreement. The Provider may then seek the balance of his/her usual and customary charges from the Provider of the other coverage.