



Provider Profile and Enrollment

Facility Name: _____

- Type of Facility:
- A. Public Health Department
 - B. Private Practice (Individual or Group)
 - C. Federally Qualified Health Center (FQHC) *
 - D. Certified Rural Health Clinic (RHC) *
 - E. Hospital
 - F. Other Facility _____
- *Note: To claim FQHC or RHC status, the facility must be certified.

Contact Person: _____
First Last Title

Vaccine Delivery Address: _____
Street Only (No P.O. Boxes)

City State Zip

Mailing Address: _____
Street or PO Box

City State Zip

Email Address: _____

Telephone: () _____ Extension _____ Fax: () _____

Vaccine Delivery Days and Times: _____

Special Instructions: (i.e. lunch hour, etc) _____

Note: Notify the Utah VFC Program if this schedule changes (vacation, closure, etc.)

PART I: Provider Agreement

To participate in the Utah Vaccines for Children (VFC) Program and receive publicly funded (CFDA 93.268, DHHS/CDC Grant 5H231P822520-05) vaccine at my facility for no cost, I agree to the following conditions, on behalf of myself and all the practitioners associated with this medical office, health department, or other health delivery facility of which I am the physician-in-chief, medical director, or equivalent:

1. I will screen patients for eligibility at all immunization encounters and administer publicly funded vaccine only to children, 0 through 18 years of age, who qualify under one or more of the following categories.
 - a) Are federally VFC vaccine eligible:
 - i. American Indian or Alaskan Native;
 - ii. Enrolled in Medicaid;
 - iii. No health insurance (un-insured);
 - iv. Under-insured – eligible only at an FQHC or RHC (has health insurance that does not include coverage of vaccines, covers only selected vaccines, or caps vaccine coverage at an annual limit).
 - b) Are state vaccine eligible:
 - i. Enrolled in the Children’s Health Insurance Program (CHIP).
2. I will immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.
3. I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the maximum fee cap of \$14.52 per dose as established by the Center for Medicare and Medicaid Services (CMS). I will accept the vaccine administration reimbursement fee set by Utah Medicaid, Utah CHIP, and contracted Medicaid/CHIP health plans.
4. I will not deny administration of a publicly funded vaccine to an established patient because the child’s parent/guardian of record is unable to pay the administration fee.

Provider Profile (continued)

PART II: Provider Profile

A. Project the number of **ALL children** (VFC eligible and non-VFC) who will receive vaccine in your facility in the 2012 calendar year, by age group.

Numbers of <u>ALL children</u> (VFC eligible and non-VFC) who will receive vaccine in your facility in the coming year:	<1 Year	1-6 Years	7-18 Years	Total

B. How many, of the children entered above in table A, are expected to be eligible for publicly funded vaccine, by age group and category?

	<1 Year	1-6 Years	7-18 Years	Total
VFC - Enrolled in Medicaid				
VFC - No health insurance				
VFC - Am. Indian/Alaskan Nat.				
VFC - Under-insured				
State - CHIP				
Total				

Type of data used to determine projections:

- | | |
|---|--|
| A. <input type="checkbox"/> Benchmarking Data | D. <input type="checkbox"/> Registry Data (USIIS) |
| B. <input type="checkbox"/> Medicaid Claims Data | E. <input type="checkbox"/> Doses Administered Data |
| C. <input type="checkbox"/> Provider Encounter Data | F. <input type="checkbox"/> Other _____
(Specify) |

PART III: Provider Information

Please **VERIFY** for accuracy the names and medical license numbers of **ALL Health Providers, including signing physician**, who may prescribe vaccine. Please make corrections or add additional providers as needed. List only those who possess a medical license or are authorized to write prescriptions.

_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medical License No.	
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
_____	_____	_____	_____
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medical License No.	

Provider Information (continued)

Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
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		Medical License No.	
Last Name, First, MI	Title (MD, DO, ND, NP, PA)	Medicaid Provider No.	Specialty Peds, Family Med, GP, Other (specify)
		Medical License No.	

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated yearly. The original form must be mailed; no faxed copies will be accepted.

Please Mail Form to:

Utah Department of Health Immunization Program
PO Box 142001 Salt Lake City, UT 84114-2001

UTAH VFC PROGRAM USE ONLY

Date Received: _____	Class Code: <input type="checkbox"/> Health Dept. <input type="checkbox"/> Private <input type="checkbox"/> FQHC/RHC <input type="checkbox"/> Hospital <input type="checkbox"/> Other Public
Date Approved: _____	Approved By: _____
VACMAN Entry Date: _____	VACMAN Entry By: _____