

Instructions for Completing the 2014 PA VFC Program Provider Agreement

The 2014 procedures and forms have been revised to meet Centers for Disease Control (CDC) requirements for new enrollment, reactivation and annual updates to participate in the VFC Program. Prior to completing the forms ensure that you have the “2014 PA VFC Program Provider Agreement Form”.

PA Vaccines for Children Program Provider Agreement

TYPE OF AGREEMENT:

1. **Types of Agreement** – Please indicate by checking either, New, Annual Renewal, or Update.

FACILITY INFORMATION:

2. **VFC PIN Number** – Provider Identification Number assigned by the PA VFC Program to providers to indicate on vaccine orders, phone inquiries, and during application renewal. It is important to place your PIN on every VFC form that is sent to the PA VFC program. (New providers that have not been assigned a PIN please leave blank.)
3. **Facility Name** – Provide the business name or “legal business name”
4. **Primary Vaccine Coordinator Name** –VFC providers must designate a Vaccine Coordinator and Back-up Vaccine Coordinator fully trained to oversee and manage the clinic’s vaccine supply.
5. **Primary Vaccine Coordinator Email** – please indicate the work email account.
6. **Back-up Vaccine Coordinator Name** – (*see above*)
7. **Back-up Vaccine Coordinator Email** – please indicate the work email account.
8. **Facility Address** – Provide the street name and street number, suite number, etc., where you would like to receive mail correspondence. Post office boxes are allowed for mail correspondence.
9. **City** – The city where you would like to receive mail correspondence.
10. **Zip Code** – The five digit code assigned to your mailing address by the U.S. Postal Service.
11. **County** – The county assigned to your mailing address.

12. **Shipping Address** – Provide the street address if different than facility address, including floors, buildings or suites where you intend to receive vaccine deliveries. (Post office boxes are NOT allowed).
13. **City** – The city where you would like to receive vaccine deliveries.
14. **Zip Code** – The five digit code assigned to your vaccine delivery address by the U. S. Postal Service
15. **County** – The county assigned to your delivery address.
16. **Telephone** – Provide the main switchboard or office/facility area code and telephone number.
17. **Fax** – Provide the main office/facility fax number including area code.
18. **Access to Internet?** – If your medical facility has access to office internet (Circle one) “Yes or No”
19. **Office Email** – if you indicated “Yes” above please indicate the work email account of the person who will be able to answer questions regarding vaccine ordering. This email address will be utilized to receive vaccine alerts and educational materials. It is important that this email is related to the medical practice and routinely accessed during working hours.

FACILITY TYPE

20. **Type of Facility** – select the type of facility that best describes your practice.
21. **Annual Patient Population** – Please carefully read each requested item based upon the number of individuals currently enrolled in your practice by “years of age”.

Please do not count a child in more than one category listed below.

- a. Total Number Enrolled in the Practice – is the total VFC eligible and non-VFC eligible (private insurance)
- b. Number of Children Enrolled in Medical Assistance
- c. Number of Uninsured Children
- d. Number of American Indian/Alaskan Native Children
- e. Number of Underinsured Children

Next, circle the type of data used to determine child population from choices provided.

- A. **Benchmarking** – A process of collecting patient population data usually over a year to estimate patient population.
 - B. **Medical Claims** – A retrospective collection of data derived from medical claims that are used to calculate an estimated patient population generally over a year period.
 - C. **Provider Encounter** – A retrospective collection of the number of children who went to a specific provider, regardless of whether or not they received any immunizations.
 - D. **Registry** – Represents PA-SIIS electronic data to determine their vaccine enrollment.
 - E. **Other** – A retrospective collection of any data that is derived by a method that is not listed in the above source data listing.
22. **Provider Vaccine Delivery Hours** – Please indicate for each day in military time/24 hour clock the hours when appropriate vaccine staff will be available to receive and properly store vaccines and supplies at the indicated vaccine delivery address. Example: Monday 0800 – 1200 1300 – 1600
23. **Providers Practicing at this facility (page 2)** – List all licensed health care providers (MD, DO) at your facility who have prescribing authority. Provide title, license # and Medicaid or NPI #, Employee Identification Number (EIN) is optional.
24. **Changes to Practice Staff** – After the initial enrollment process any changes in physician practice staff should be indicated in the Add or Delete section.
25. **Annual Training** – For re-enrollment only check to indicate if your facility’s VFC Coordinator has completed the annual VFC training requirement.
26. **Provider Agreement (pages 3 & 4)** – In order to participate in the PA VFC Program and or receive federally procured vaccine provided at no cost, a facility’s medical director or equivalent must read and agree to each of the requirements listed.

MEDICAL DIRECTOR OR EQUIVALENT

First, MI, Last Name – The name of the official VFC registered Physician provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the PA VFC Program Provider Agreement

Title – Provide the title of the person listed as Medical Director

Specialty – Provide the specialty of person indicated as Medical Director

Physician License # – Provide the Pennsylvania Physician license number for the person listed as Medical Director

Medicaid or NPI # – Provide the Medicaid or NPI Number for the person listed as Medical Director

27. **Electronic Signature** - On behalf of the applying medical facility, the Medical Director (or equivalent) must acknowledge via checking the box. If completing via hard-copy please check the box and hand sign below to comply with the policies and procedures stated on this enrollment form.
28. **Provider's Signature** – enter the name of the Medical Director (or equivalent) if manually completing provide his/her hand signature.
29. **Date** – The date the indicated Medical Director (or equivalent) signed the “2014 PA VFC Program Provider Agreement”.

Any questions or concerns please contact the PA VFC line at 888 646-6864.

SUBMISSION OF THE COMPLETE INFORMATION.

If you manually completed the enrollment form you must fax or mailed to: Pennsylvania Department of Health, Division of Immunizations, 625 Forster Street, Room 1026, Harrisburg, PA 17120. Fax: 717-214-7223, Phone: 717-787-5681

Following the processing of the completed enrollment form an on-site enrollment visit and training session will be scheduled for new enrollments or re-enrollments. The enrollment training will include a review of VFC Program requirements, as well as give the provider the opportunity to ask questions regarding any segment of the VFC Program.

A copy of the original enrollment form should be retained by the primary contact person.

Note:

Section 1928 (c) (1) (A) of the Social Security Act (42 U.S.C. 1396s (c) (1) (A) states that the following providers qualify to be VFC program-registered providers: those healthcare providers "licensed or otherwise authorized for administration of pediatric vaccines under the law of the State in which the administration occurs" (subject to section 333 (e) of the Public Health Service Act, which authorizes members of the Commissioned Corps to practice).