Connecticut Vaccine Program

2016 Provider Agreement

Completed forms can be FAXED to: 860-509-8371 or EMAILED TO: dph.immunizations@ct.gov

FACILITY INFORMATION

Facility Name:			PIN:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official registered health care 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 providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	Employer Identification #: *(optional):*
Provide Information for second individual as needed (for pharmacists only):		
Last Name, First, MI:	Title:	Specialty:
License #:	Medicaid #:	Employer Identification #: *(optional):*

VACCINE COORDINATOR

Primary Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: ○ Yes ○ No	Type of training received: ☐ Site visit ☐ CDC on-line modules ☐ Other/specify:
Back-Up Vaccine Coordinator* Name:	
Telephone:	Email: (NOTE: this email address will receive CVP communications)
Completed annual training: ○ Yes ○ No	Type of training received: ☐ Site visit ☐ CDC on-line modules ☐ Other/specify:

*The primary vaccine coordinator is the person at the office who has primary responsibility for ordering, monitoring, and ensuring the quality of vaccines at the practice; the back-up vaccine coordinator has responsibility in the vaccine coordinator's absence.

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PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License #	Medicaid #	Employer ID# *(Optional)*

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PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories: A. Federal Vaccine-eligible Children (VFC eligible) 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement. B. State Vaccine-eligible Children 1. In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible", I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses to such children. Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are **not** eligible to receive VFC-purchased vaccine.
3.	For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the vaccine program for a minimum of three years and upon request make these records available for review. Vaccine records include, but are not limited to, vaccine screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	VFC Vaccine Eligible Children I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible (uninsured or under-insured) children that exceeds the administration fee cap of $21.00 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans. State Vaccine Eligible Children For private insurance patients I will accept the reimbursement for immunization administration up to the maximum allowed per the insurance company's policy.

7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
9.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Connecticut Vaccine Program storage and handling requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
10.	I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program: **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	Should my staff, representative, or I access VTrckS, I agree to: a) Be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines, and b) In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform the Connecticut Vaccine Program within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
13.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: a) Vaccinate all "walk-in" VFC-eligible children and b) Not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. Note: *"Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.*
14.	I agree to replace vaccine purchased with state and federal funds that are deemed non-viable due to provider negligence on a dose-for-dose basis.
15.	I understand this facility or the Connecticut Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused state and federal vaccine as directed by the Connecticut Vaccine Program.

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By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the vaccine enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:
Name (print) *Second individual as needed*:	
Signature:	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License #	Medicaid #	Employer ID# *(Optional)*