STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TO: **All Users of State Supplied Vaccines**

FROM: **Mick Bolduc**
Vaccines For Children (VFC) Coordinator

DATE: **January 4, 2010**

SUBJECT: **VFC Re-enrollment**

As part of the federal requirement to receive free vaccines under the Vaccines For Children (VFC) program every provider must complete and return the Provider Profile and Provider Agreement forms on a yearly basis. Please fill out the enclosed forms as completely and accurately as possible paying special attention to the section asking for shipping information including the days and hours your office is open. **Be sure to include any times the office is closed including lunch periods.**

As a reminder the maximum administration fee **that can be charged (i.e. collected) to uninsured and underinsured patients** is $21 per dose. The $21 fee is to keep out of pocket costs for uninsured or underinsured patients to a minimum. The fee for Medicaid patients continues to be the fee established by the Department of Social Services. The administration fee for private insurance patients can be up to the maximum allowed per the insurance company's policy. Many providers have commented that they cannot charge different administration fees for the same services rendered (e.g. $30 to a private insurance patient, and $21 to an uninsured/underinsured client). The provider agreement language allows providers to bill one fee regardless of the patients' status, but only allows them to collect a maximum of $21 per dose administered from uninsured and underinsured patients. Any remaining balance would have to be written off as you would with your Medicaid and private insurance patients.

The completed Provider Profile and Agreement forms must be signed, dated and returned to the Immunization Program by January 29, 2010 in order to continue receiving vaccines on an uninterrupted basis. The forms can either be mailed or faxed. Our fax number is (860) 509-8371. Please remember to fill in your four digit Provider Identification Number (PIN) on the top right hand corner of the Provider Agreement form.

As always, please feel free to contact me at (860) 509-7929 with any questions. Thank you for your continued participation in the Connecticut VFC Program.

Provider Profile

PIN:

Connecticut Vaccines For Children Program

All public and private health care providers who receive vaccine from the Connecticut Vaccines for Children Program **(VFC)** must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Immunization Program will keep this record on file with the SIGNED **"*Provider Agreement"*** on the back of this page. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the status of the facility changes. Complete one form for each office/site/satellite.

Federal Employer Tax ID: _____ Group Medicaid Billing Number: _____

Please provide the following information for all personnel who administer vaccines.

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

RN, APRN _____ CT License # _____ Medicaid Billing # _____

Other _____ Other License # _____ Medicaid Billing # _____

Shipping Address:

Facility/Provider Name: _____

Contact Person: _____

Street Address (no P.O. Boxes): _____

City, State, Zip: _____

+Phone # _____ Fax # _____

+If possible, we would like this number to be a direct line to the person who orders the vaccines.

Office Days and Hours: _____

Indicate the Type of Facility (please check one only):

_____ 10 Public Health Department
_____ 12 Public Hospital
_____ 16 Other Public (please specify: _____
_____ 15 Federally Qualified Health Center (FQHC) or federally funded Rural Health Clinic
_____ 20 Private Practice (Individual or Group)
_____ 22 Private Hospital
_____ 24 Other Private (Please specify _____

	Birth to 2 yrs	3-6 yrs	7-18 yrs	> 18 yrs	Total
Total Patients in practice needing state supplied Immunizations (by age):	_____	_____	_____	_____	_____

Breakdown how many of the children you entered above into the categories below:
(Please do not count a child in more than one category or use percentages.)

	Birth to 2 yrs	3-6 yrs	7-18 yrs	Total
31 Enrolled in Medicaid	_____	_____	_____	_____
32 Without Health Insurance	_____	_____	_____	_____
33 American Indian or Alaskan Native	_____	_____	_____	_____
*44 Underinsured	_____	_____	_____	_____

* (Complete ***44 Underinsured*** only if your facility is an FQHC, an agent of an FQHC or an RHC (see 15 above)

These numbers must be entered in order to receive vaccines. New providers should give an estimate.
PLEASE remember to sign the ***"Provider Agreement"*** on the back of this page.

In the future, we may use e-mail for some communications; please give us the e-mail address for your facility.

_____@_____

Return to: State of Connecticut, Department of Public Health; 410 Capitol Avenue, M.S. # 11MUN Hartford, CT 06134-0308
Program Phone: 860-509-7929 Fax: 860-509-8371

Revised 12/1/08

Connecticut Department of Health

Vaccines for Children Program Provider Agreement PIN:

_____ agrees to participate in the Connecticut Vaccines for Children (VFC) Program through which _____ will
Provider Name Facility Name

receive publicly purchased vaccines and agrees it:

1. shall not impose a charge for the cost of the vaccine received through this program; however may charge a reasonable administration fee per dose given. The administration fee charged to uninsured or underinsured children cannot exceed $21 per dose; the administration fee for all Medicaid recipients shall be the fee schedule established by the Department of Social Services, the administration fee for private insurance patients can be up to the maximum allowed per the insurance company's policy.
2. shall not deny administration of a VFC supplied vaccine to a VFC eligible child due to the inability of the child's parent/guardian/individual of record to pay an administration fee.
3. shall not bill a third party (e.g. insurance company or Medicaid) for vaccines already purchased with public (including VFC) funds. For the purpose of this agreement, multiple antigens such as MMR, MMRV, Td, DTaP, Tdap, DTaP/IPV/HepB, DTaP/IPV/Hib, and DTaP/IPV are considered to be one vaccine.
4. shall provide the Connecticut Immunization Program with the numbers of children 0-18 years of age expected to need immunizations at this facility/practice for the 12-month period beginning on January 1, 2010. This information shall be submitted to DPH on the form entitled PROVIDER PROFILE as part of the annual procedure to enroll in the Connecticut VFC Program to receive publicly purchased vaccines.
5. shall screen patients using a screening eligibility record at all immunization encounters for eligibility and administer VFC vaccine to those children 18 years of age and younger who are: (A) enrolled in the Medicaid Program (or qualifies through a State's Medicaid waiver), (B) has no health insurance/self pay, (C) are American Indians or Alaskan natives, (D) are underinsured/has health insurance that does not pay for vaccinations (only applicable to FQHCs or RHCs), or (E) has private insurance (private insurance patients can only receive those vaccines that are universally provided through the state Immunization Program).
6. shall comply with the appropriate immunization schedule, dosage, and contraindications, approved by the DHHS Advisory Committee on Immunization Practices (ACIP), unless (a) in the exercise of medical judgment, and in accordance with accepted medical practice, deem such compliance to be medically inappropriate; or (b) the particular requirement contradicts the Connecticut General Statute Sections 19a-7f, 10-204a and 19a-79-6a pertaining to immunizations and school and daycare immunization requirements for children in CT, including regulations relating to religious or medical exemptions.
7. shall provide Vaccine Information Statements (VIS) 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).
8. shall maintain all VFC-related records for a period of three (3) years and if requested, shall make such records available to the Department of Public Health or the U.S. Department of Health and Human Services (DHHS).
9. shall comply with the Immunization Program requirements for ordering vaccines and with other requirements as detailed on the Vaccine Order Form (VOF) including the reporting of doses of vaccine administered by broad age categories and by dose number in the series on the order form provided by the Immunization Program.
10. shall maintain good vaccine handling and storage practices and shall report to the Immunization Program any vaccine wastage/loss.
11. shall report adverse reactions (reactions requiring medical attention) associated with vaccine to DPH within two weeks of the event occuring by phone or fax.
12. agrees that only licensed personnel shall administer vaccines to patients.
13. agrees that the Department of Public Health shall be granted access to the practice/clinic to conduct program and patient record reviews.
14. understands that either party may terminate this agreement at any time for any reason. The provider shall give 30 days written notice before terminating this agreement. The Department of Public Health may terminate this agreement for failure of the provider to comply with all the requirements.
15. shall properly return any unused VFC vaccine upon termination of this agreement.
16. the effective date of this Agreement is January 1, 2010. This Agreement shall thereafter be in effect for a period of 12 months, ending December 31, 2010 unless terminated by either party prior to the stated ending date. This agreement supersedes any previously signed agreement.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

_____
Provider Name

_____
Name of Authorized Representative (Must be an Authorized Officer, Owner, or Partner) (**Please Print)**

_____ _____
Signature of Authorized Representative Date

This record is to be submitted to and kept on file at the Connecticut Immunization Program and must be updated at least once annually. A copy of this form shall be retained at the provider's office. It shall be shared with all relevant persons at the facility/practice including persons administering vaccines, staff responsible for billing procedures and any others determined at the provider site that need to know the information herein.