New Provider Enrollment Form

All public and private health care providers who receive vaccine from the Connecticut Vaccine Program (CVP) **must complete this enrollment form. Once we receive this, we will contact you to schedule a site visit where we will go over the requirements of the program as well as review storage units/data loggers used to store CVP vaccines. Once the provider is approved, you will be asked to request access to CT WiZ and be required to report and order through CT WiZ.**

Please send completed enrollment to dph.immunizations@ct.gov

Click To Submit

CLINIC INFORMATION		
Clinic Name:		PIN:
Part of a Provider Group: ☐ No ☐ Yes Name:		
Clinic Category: ☐ Pharmacy ☐ Private Provider ☐ Public Health ☐ Other:		
Mailing Address:		
City:		
County:	State: CT	Zip Code:
Shipping Address: ☐ *Check here if same as Mailing Address*		
City:		
County:	State: CT	Zip Code:

CONTACT INFORMATION	
The primary and backup coordinators are responsible for the storage and handling of the vaccine as well as the inventory, ordering, etc. Please see Vaccine Coordinator role document listed on our website for more information.	
Primary Coordinator:	Title:
Phone Number:	Fax Number:
Email:	
Back-Up Coordinator:	Title:
Phone Number:	Fax Number:
Email:	
This will be the Physician signing the agreement (or equivalent). To view the agreement, visit our website. Upon completing a new provider enrollment visit with a DPH staff member, the Physician signing the agreement (or equivalent) will be required to sign into CT WiZ yearly to electronically sign off on the agreement.	
Physician Signing the Agreement/Medical Director:	

New Provider Enrollment Form

INSURANCE BREAKDOWN

This is the insurance breakdown of your patients at your practice. Please be as accurate as possible.

	Birth to 1 yr.	1-6 yrs.	7-18 yrs.	Total
VFC Eligible-Medicaid/Medicaid Managed Care (Husky A)				0
VFC Eligible-Uninsured (Patients without Insurance)				0
VFC Eligible- American Indian/Alaska Native				0
CHIP (Husky B)				0
VFC Eligible-Underinsured at FQHC				0
Not VFC Eligible (Private Insurance)				0
Total Number of All Patients in your practice who will be administered state supplied vaccine (must equal the sum total for rows 1-6 above)	0	0	0	0