PROVIDER ENROLLMENT FORM
MARYLAND VACCINES FOR CHILDREN PROGRAM
Complete One Form for Each Provider Site to which Vaccine Should be Shipped

Physician/Clinic: ______________________________________________________________________
Address: ________________
Telephone No.: (___)____________________________ FAX No.: (____)________________________
Alternate Telephone No.: (____)________________________
Contact Name(s): __________________________________ Provider MA Billing No.: ________________
Shipping Instructions (Days vaccines cannot be received):______________________________________

In order to participate in the Maryland Vaccines for Children (MD VFC) Program and/or receives other
federally procured vaccine provided to me at no cost, I, on behalf of myself and any and all
practitioners associated with this provider site agree to the following:

1. Screen patients at all immunization encounters and administer MD VFC Program-purchased vaccine
   only to a child < 18 years of age who: (a) is enrolled in Maryland Medicaid, or (b) has no health
   insurance, or (c) is an American Indian or Alaskan Native.
2. Administer MD VFC Program 317 purchased vaccine only to a child < 18 years of age who
   has health insurance that does not pay for vaccines.
3. I will maintain the Patient Eligibility Screening Records for a period of six years. Because the MD
   VFC program is Medicaid funded, release of these records will be bound by the privacy protection of
   the Federal Medicaid law and confidentiality provisions of Maryland law.
4. If requested, I will make the Patient Eligibility Screening Records and immunizations records on
   children covered by the MD VFC program available to the Maryland Department of Health and Mental
   Hygiene (DHMH) or the Department of Health and Human Services (DHHS).
5. I will Comply with immunization schedule, dosage, and contraindications that are established by the
   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
   b) The particular requirements contradict state law, including those pertaining to religious and
      other exemptions
6. I will administer vaccines as appropriate according to the recommended schedule as established by
   ACIP and outlined in the Maryland Immunization Schedule, approved by MedChi, based on my
   clinical judgement.
7. I will provide the most current Vaccine Information Statements (VISs) and maintain Patient Vaccine
   records in accordance with the National Childhood Vaccine Injury Act of 1986.
8. I will not impose a charge for the cost of the vaccine received through the MD VFC program.
9. I will not impose a charge for the administration of the vaccine in any amount higher than the
   maximum fee ($15.49/per dose) established by DHHS for uninsured and underinsured children.
10. I will not deny administration of a federally procured vaccine to a child due to the inability of the child’s
    parent/guardian/individual of record to pay an administration fee.
11. I will comply with the State’s requirements for reporting VFC vaccine inventories on DHMH 4499.
12. Follow appropriate vaccine storage and handling procedures.
13. Participate in an Annual MD VFC site review.
14. I may terminate this agreement at any time. The State of Maryland may terminate this agreement for
    failure to comply with these requirements.

_____________________________ ______________________________ ____________________
Provider Signature Provider Name (Please Print) Date

Send to:
Maryland Department of Health and Mental Hygiene
Maryland Vaccines for Children Program
201 West Preston Street RM 318
Baltimore, MD 21201

The Maryland Department of Health and Mental Hygiene will keep this Enrollment Form on file.
DHMH 4495 (09/07) www.EDCP.org, Click “Immunization”
FOR STATE USE ONLY: Date Certified: _____________________________

ADDENDUM TO VFC PROVIDER ENROLLMENT FORM (for OB/GYNs)

In addition to terms 1 -14 on the Maryland Vaccines for Children Program Enrollment Form, I, on behalf of myself and any and all practitioners associated with this provider site agree to the following:

15. I will complete the Log of Human papilloma virus (HPV) Doses Administered and fax it to the VFC Program, in order to receive replacement HPV vaccine.

_____________________________________________ _______________  _______________ 
Physician Signature Date
VFC PIN (Assigned by VFC):

Maryland VFC Program Provider Enrollment Attachment
Additional Providers within the Practice

Please print the names and medical license numbers of the other health providers who may administer vaccine. It is not necessary to include the names of all staff who may administer vaccine, only those who possess a medical license or are authorized to write prescriptions. If you require more space, please make a copy of this form.

<table>
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<tr>
<th>Last Name, First, MI</th>
<th>Medical License No.</th>
<th>Title (MD, DO, NP, PA)</th>
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<td>Specialty (Peds, Family, Med, Gen. Practitioner)</td>
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</table>
Maryland Vaccines for Children Program
Provider Profile Form

DATE_________________

All newly enrolled MD VFC enrolled providers must complete this form. This form is used to determine your anticipated MD VFC vaccine needs. You must update this Provider Profile Form if: 1. your estimates of children served changes, or 2. the status of your practice changes (e.g. change in location of your practice, change in your Federal tax ID). If you are a group practice, only one provider needs to complete this form for the entire practice. If you have multiple practice sites, complete a separate Provider Profile Form for each site to which you want vaccine. (Instructions for completing the form can be found on the next page)

A. MD VFC PIN                MA Billing number                Federal Tax ID number                Medical License Number

B. Facility Name                Provider Last Name                Provider First Name

C. Contact Last Name                Contact First Name

D. Vaccine Delivery Address                City                State                Zip Code

              Telephone Number                Fax Number

(            )                (            )

E. Facility Type (Check One)

Private Practice (individual or group)                Private Hospital                Public (LHD only)

Provider Profile: Note: All boxes must be complete

F. For the next 12 months, estimate the total number of children who will receive vaccinations at your practice by age. (Children covered by commercial insurance and VFC-eligible)

<1 Year                1-6 Years                7-18 Years                TOTAL

G. Of the totals above, how many children do you expect to be VFC-eligible because they are/have:

Note: These boxes below must be filled in even if the numbers are estimates; Do not count a child in more than one category. Do not add the figures above with the total VFC eligible figures below!

Enrolled in Medicaid (any type including MCO and HMO):

No health Insurance (uninsured)

Native American or Alaskan Native

Underinsured (i.e., has insurance that does not cover vaccine)

Total VFC-eligible

DHMH 4496 (rev. 02/02)    Mail or FAX to MD VFC Program, 201 W Preston Street, Room 416, Baltimore, MD 21201 FAX: 410-333-5893
Instructions for Completing the Provider Profile Form (DHMH 4496)

Date: Please enter the date you submit the form to the VFC Program.

Parts A through E:

These fields request practice demographic information. Please complete Medical License number. If any of the information has changed (with the exception of MD VFC PIN), please provide updated information. (Note: Only current enrollees have a PIN assigned)

Part F:

This portion of the profile asks for an estimate of all children who will receive vaccinations at your practice for the next 12 months. Please estimate all children, VFC eligible and non-VFC eligible (children covered by insurance plans including well child services). Do not provide a figure that combines the three columns! Please enter the estimates in the appropriate columns and give a total in the fourth column.

Part G:

Part G asks for the expected number of VFC-eligible children who will receive vaccinations at your practice for the 12 month period beginning. Please enter the number of children in each age group and each VFC eligibility category (enrolled in Medicaid, uninsured, Native American/Alaskan Native, and underinsured). Do not count a child in more than one category. Please check that the total of these actually matches the entries in the row labeled Total VFC-eligible at the bottom of the Profile. Utilize the comments area to explain how numbers were derived. The grand total of VFC-eligible children (Part G) should be less than the total children receiving vaccination at your site (part F). DO NOT ADD F & G!