

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):

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**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.

Last Name, First, MI	Medical License No.	Title (MD, DO, NP, PA)
	Specialty (Peds, Family, Med, Gen. Practitioner)	Medicaid Provider No.
Last Name, First, MI	Medical License No.	Title (MD, DO, NP, PA)
	Specialty (Peds, Family, Med, Gen. Practitioner)	Medicaid Provider No.
Last Name, First, MI	Medical License No.	Title (MD, DO, NP, PA)
	Specialty (Peds, Family, Med, Gen. Practitioner)	Medicaid Provider No.
Last Name, First, MI	Medical License No.	Title (MD, DO, NP, PA)
	Specialty (Peds, Family, Med, Gen. Practitioner)	Medicaid Provider No.

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 Number **MA Billing number** **Federal Tax ID number** **Medical License**

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: <u>All boxes</u> must be complete	<1 Year	1-6 Years	7-18 Years	TOTAL
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)				
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!**