



## Adult Immunization Program Provider

### VFC Provider Enrollment Agreement

These directions are intended to provide step-by-step instructions for completing the Vaccines for Children (VFC) Program's annual re-enrollment, which is required for all participating VFC providers.

1. Click on the "VFC RE-ENROLLMENT FORMS":



2. Please review all information in this section to confirm that it is correct. If there is any information that is inaccurate, please click on the "Edit VFC Profile" button above to make any necessary corrections. Then, in the dropdown list under "Organization Type", select **ADULT IMMUNIZATION PROGRAM PROVIDER**:

home manage access/account forms related links logout help desk training

organization IR Physicians • user Ernad Klipic • role VFC Administrator

VFC Re-Enrollment Forms - Adult Immunization Program Provider

Facility Information

Facility Name: IR Physicians Edit VFC Profile

Provider Pin: 33333Z

Shipping Address: 455 Main Address

City: Omaha

County: Adams

State: NE

Zip: 68501 +4: 8080

Telephone: 981 080 0808 Ext. 8080980808

Fax: 881 808 6860

**Warning:** Please review all information in this section to confirm that it is correct. If there is any information that is inaccurate, please click on the "Edit VFC Profile" button above to make any necessary corrections.

Organization Type

Adult Immunization Program Provider

Birth Dose Hospital

Adult Immunization Program Provider

Vaccines for Children Provider

Facility Address (if different than S

Facility Address:

City:

Zip: +4:

3. All fields in **blue** are required:

Organization Type	
Adult Immunization Program Provider ▼	
Facility Address (if different than Shipping Address)	
Facility Address:	<input type="text"/>
City:	<input type="text"/>
Zip:	<input type="text"/> +4: <input type="text"/>
Medical Director or Equivalent	
*Last Name:	<input type="text" value="Jackson"/>
*First Name:	<input type="text" value="Sandra"/>
Middle Initial:	<input type="text"/>
*Medical License Number:	<input type="text" value="2541524"/>
*Medicaid/NPI Number:	<input type="text" value="12452154"/>

4. List all licensed health care providers (MD, DO) at your facility who have prescribing authority. Provide title, license # and Medicaid or NPI #. Then click **ADD** button:

Providers Practicing at this Facility	
*Last Name:	<input type="text" value="Roberts"/>
*First Name:	<input type="text" value="Rachel"/>
Middle Initial:	<input type="text"/>
*Medical License Number:	<input type="text" value="2233"/>
*Title:	<input type="text" value="MD"/>
*Medicaid/NPI Number:	<input type="text" value="3541417"/>
<input type="button" value="Add"/>	


5. Please read the agreement carefully and make sure you fully understand its content.

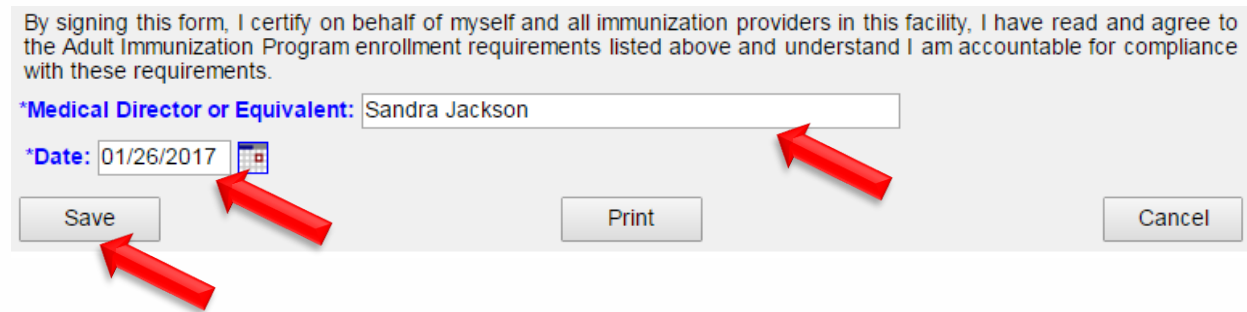
Agreement
<p>To receive publicly funded vaccines at no cost I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director or practice administrator or equivalent:</p> <ul style="list-style-type: none"><li>• I will screen patients and document eligibility status at each immunization encounter for AIP eligibility and administer AIP purchased vaccine only to adults who are 19 years of age or older who meet one of the following categories:<ul style="list-style-type: none"><li>◦ have no health insurance</li><li>◦ are underinsured: A person who has health insurance, but the coverage does not include vaccines; a person whose insurance covers only selected vaccines (AIP-eligible for non-covered vaccines only).</li></ul></li><li>• I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the AIP program unless:<ul style="list-style-type: none"><li>◦ In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate;</li><li>◦ The particular requirements contradict state law, including laws pertaining to religious and other exemptions.</li></ul></li><li>• I will maintain all records related to the AIP program for a minimum of three years, or longer if required by state law, and make these records available to public health officials, including the state or Department of Health and Human Services, (DHHS) upon request.</li><li>• I will immunize eligible adults with AIP-supplied vaccine at no charge to the patient for the vaccine.</li></ul>

- To complete the form, please enter the Medical Director's name previously entered on the form and date and then click SAVE:

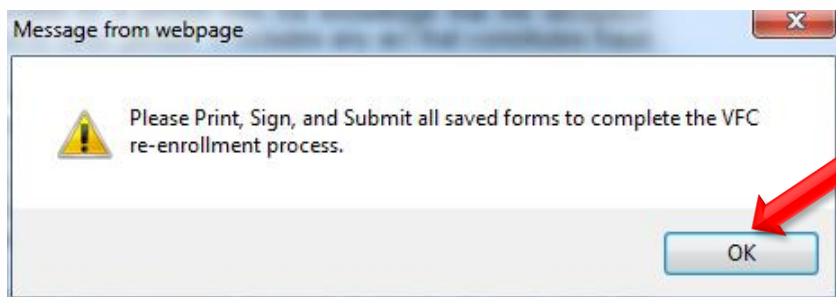
By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Adult Immunization Program enrollment requirements listed above and understand I am accountable for compliance with these requirements.

**\*Medical Director or Equivalent:**

**\*Date:**  



- Now a pop-up message will appear. Click the OK button:



**NOTE:** If you click "Save" before completing the form, a pop-up box will display, stating "Warning: You have not completed this re-enrollment form. Saving now will not complete the re-enrollment process. You must complete and print all forms before online re-enrollment is completed."

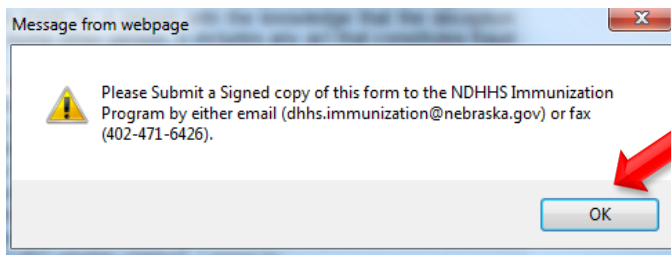
- Clicking on it will take you to the top of the page, scroll down the page and verify/update the listed information then click PRINT:

**\*Medical Director or Equivalent:**

**\*Date:**  



- Selecting PRINT will display a pop-up box with the following message, "Please Submit a Signed copy of this form to the NDHHS Immunization Program by either email [dhhs.immunization@nebraska.gov](mailto:dhhs.immunization@nebraska.gov) or fax (402-471-6426)." Select the "OK" button to close the pop-up box:



Please review, print, sign, and fax the forms to the Immunization Program at 402-471-6426 or email it to [dhhs.immunization@nebraska.gov](mailto:dhhs.immunization@nebraska.gov).