Vaccines for Children Program
Bureau of Immunization
NYC DOHMH
42-09 28th Street, 5th Floor, CN-21
Queens, New York, 11101-4132
Phone: (347) 396-2404 / Fax: (347) 396-2559

PROVIDER INFORMATION FORM

FOR NEW ENROLLMENTS OR TO UPDATE PROVIDER INFORMATION

To update provider information, please complete the whole form and check the boxes "Updates Made to This Section" when applicable

*(Please complete all *required fields & return by fax or mail)*

PRACTICE/GROUP PRACTICE/CLINIC/FACILITY NAME:* _____

PROGRAM STATUS:* ☐ New Enrollment **OR** ☐ Currently Enrolled PIN NUMBER:_____ FACILITY CODE: _____

FACILITY CLASSIFICATION:

☐ **UPDATES MADE TO THIS SECTION**

***Practice Type** (*age group your facility serves*): ☐ Pediatric (i.e., Child<19) ☐ Adult ☐ Both

***Funding Class** (*primary source of funding at this site*):

☐ Private

***Sector** (describes your organization type)
- ☐ Private Practice
  - **Setting:** In NYC
  - **Specialty:** _____

OR
- ☐ Hospital
  - **Setting:** _____
  - **Specialty:** _____

OR
- ☐ Other Medical Facility
  - **Sub Sector:** _____
  - **Specialty:** _____

☐ Public

***Sector** (describes your organization type)
- ☐ Public Health Department
  - **Sub Sector:** _____
  - **Specialty:** _____

OR
- ☐ Hospital
  - **Sub Sector:** _____
  - **Specialty:** _____

OR
- ☐ Other Medical Facility
  - **Sub Sector:** _____
  - **Specialty:** _____

☐ FQHC

***Sector** (describes your organization type)
- ☐ Hospital

OR
- ☐ Community Health Center

Subsector:
- ☐ Homeless Center
- ☐ Drug Rehabilitation
- ☐ Clinic – Offsite/Satelite
- ☐ Mobile Unit
- ☐ School Based Clinic
- ☐ Other: _____

SHIPPING ADDRESS (*refers to the address where your vaccines will be shipped*):

☐ **UPDATES MADE TO THIS SECTION**

*Address Line1 : _____ Address Line 2: _____

*Borough: _____ *State: New York *Zip Code: _____

*Telephone Number: _____ Ext. _____ *Fax: _____

*Email Address: _____ Cell Phone: _____

*Shipping Contact (*please only choose one*):

☐ Physician-In-Charge ☐ Vaccine Coordinator ☐ Backup Vaccine Coordinator ☐ Additional Contact

SHIPPING HOURS* (*days/times when your facility can receive vaccine shipments*):

☐ **UPDATES MADE TO THIS SECTION**

		First Open Interval		Second Open Interval	
		From	To	From	To
Monday	☐ Office is closed/no deliveries				
Tuesday	☐ Office is closed/no deliveries				
Wednesday	☐ Office is closed/no deliveries				
Thursday	☐ Office is closed/no deliveries				
Friday	☐ Office is closed/no deliveries				

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PHYSICIAN-IN-CHARGE (PIC)

☐ UPDATES MADE TO THIS SECTION

This title refers to the main physician involved with VFC vaccines.

Please note that the PIC can be PIC and VC OR PIC and BVC, but CANNOT be all three (PIC, VC, and BVC).

*First Name: _____ *Last Name: _____

Medicaid Provider Name: _____ *NYS Medical License Number: _____

Job Title: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: New York *Zip Code: _____

*Telephone Number: _____ Ext. _____ *Fax Number: _____

*Email Address: _____ Cell Phone: _____

VACCINE COORDINATOR (VC)

☐ UPDATES MADE TO THIS SECTION

*Type: ☐ Physician ☐ Non-Physician ☐ **Vaccine Coordinator is Same as Physician-In-Charge**

*First Name: _____ *Last Name: _____

Job Title: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: New York *Zip Code: _____

*Telephone Number: _____ Ext. _____ *Fax Number: _____

*Email Address: _____ Cell Phone: _____

BACK-UP VACCINE COORDINATOR (BVC)

☐ UPDATES MADE TO THIS SECTION

*Type: ☐ Physician ☐ Non-Physician ☐ **Back-up Vaccine Coordinator is Same as Physician-In-Charge**

*First Name: _____ *Last Name: _____

Job Title: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: New York *Zip Code: _____

*Telephone Number: _____ Ext. _____ *Fax Number: _____

*Email Address: _____ Cell Phone: _____

ADDITIONAL CONTACT (*optional*)

☐ UPDATES MADE TO THIS SECTION

*Type: ☐ Physician ☐ Non-Physician

*First Name: _____ *Last Name: _____

Job Title: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: New York *Zip Code: _____

*Telephone Number: _____ Ext. _____ *Fax Number: _____

*Email Address: _____ Cell Phone: _____

Health

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ANNUAL PATIENT NUMBERS*

☐ UPDATES MADE TO THIS SECTION

Please report the number of children immunized yearly in each of the categories listed below. Do NOT enter percentages, symbols, etc. Incomplete information may result in the delay of your enrollment.

Category	<1 Year	1-6 Years	7-18 Years	≥ 19 Years
Medicaid/Medicaid Managed Care				
Not Insured/No Insurance				
American Indian/Alaskan Native				
Underinsured*				
Child Health Plus B (CHPlus B)				
Not Eligible**				
TOTAL				

*Underinsured – Children who have commercial (private) health insurance but does not cover vaccines, children whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (when amount is reached, children are categorized as underinsured).

**Not Eligible – Insurance covers all or part of the cost of vaccine.

Type of data used to determine profile:*

☐ Benchmarking ☐ Dose Administered ☐ Registry
☐ Medicaid Claims Data ☐ Provider Encounter Data ☐ Other (specify): _____

PRACTITIONER LIST*

☐ UPDATES MADE TO THIS SECTION

Please list all immunizing staff at your facility; including anyone you listed above (attach additional sheets if necessary).

First Name*	Last Name*	Degree*	Medicaid Provider #	NYS Medical License #*	Email

ADDITIONAL SITES

☐ UPDATES MADE TO THIS SECTION

List additional practices/satellite programs. If the practices/satellite is already enrolled with VFC, please provide the VFC Pin number. Practices/satellite sites may be enrolled by completing a separate enrollment package for each (attach additional sheets if necessary).

Facility Name	Zip Code	Is this site VFC Enrolled	If Yes, please provide PIN