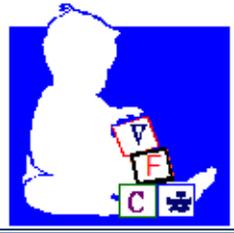




Vaccines for Children Program  
 Bureau of Immunization  
 NYC DOHMH  
 42-09 28<sup>th</sup> Street, 5<sup>th</sup> Floor, CN-21  
 Queens, New York, 11101-4132  
 Phone: (347) 396-2404 / Fax: (347) 396-2559



## 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):

<input type="checkbox"/> Private *Sector (describes your organization type) <input type="checkbox"/> Private Practice Setting: In NYC Specialty: _____ OR <input type="checkbox"/> Hospital Setting: _____ Specialty: _____ OR <input type="checkbox"/> Other Medical Facility Sub Sector: _____ Specialty: _____	<input type="checkbox"/> Public *Sector (describes your organization type) <input type="checkbox"/> Public Health Department Sub Sector: _____ Specialty: _____ OR <input type="checkbox"/> Hospital Sub Sector: _____ Specialty: _____ OR <input type="checkbox"/> Other Medical Facility Sub Sector: _____ Specialty: _____	<input type="checkbox"/> FQHC *Sector (describes your organization type) <input type="checkbox"/> Hospital OR <input type="checkbox"/> Community Health Center Subsector: <input type="checkbox"/> Homeless Center <input type="checkbox"/> Drug Rehabilitation <input type="checkbox"/> Clinic - Offsite/Satellite <input type="checkbox"/> Mobile Unit <input type="checkbox"/> School Based Clinic <input type="checkbox"/> Other: _____
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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: \_\_\_\_\_

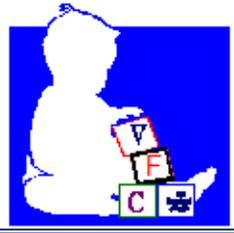
\*Shipping Contact (please only choose one):  
 Physician-In-Charge  Vaccine Coordinator  Backup Vaccine Coordinator  Additional Contact

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	<input type="checkbox"/> Office is closed/no deliveries				
Tuesday	<input type="checkbox"/> Office is closed/no deliveries				
Wednesday	<input type="checkbox"/> Office is closed/no deliveries				
Thursday	<input type="checkbox"/> Office is closed/no deliveries				
Friday	<input type="checkbox"/> 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: \_\_\_\_\_

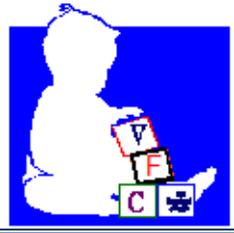
**ADDITIONAL CONTACT (optional)**

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: \_\_\_\_\_



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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**				
<b>TOTAL</b>				

\*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:\***

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Benchmarking         | <input type="checkbox"/> Dose Administered       | <input type="checkbox"/> Registry               |
| <input type="checkbox"/> Medicaid Claims Data | <input type="checkbox"/> Provider Encounter Data | <input type="checkbox"/> 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