New Jersey Department of Health
Vaccines for Children (NJVFC) Program
PO Box 369
Trenton, NJ 08625-0369
Phone: (609) 826-4862 Fax: (609) 826-4867

PROVIDER ENROLLMENT

This form is to be completed for each provider site location and is to be signed by the lead physician for the practice.

Site Medicaid ID Number ***(Mandatory)***	PIN Number	New Provider? ☐ Yes ☐ No
Site Name		NPI Number
Address		
Name of Contact Person(s)		
Telephone Number ( )	Fax Number ( )	
Medical License Number of Lead Physician	Business Email Address ***(Mandatory)***	
Is your practice/clinic a Federally Qualified Health Center (FQHC) ☐ Yes ☐ No	Is your practice/clinic a Rural Health Center (RHC)? ☐ Yes ☐ No	

In order to participate in the New Jersey Vaccines For Children (NJVFC) Program and/or to receive other federally procured vaccine provided to me at no cost, I, on behalf of myself and any and all practitioners, nurses and others associated with this medical office, group practice, managed care organization, health department, community/migrant/rural clinic, or other entity of which I am the physician-in-chief or equivalent, agree to the following:

1. I will screen patients and administer NJVFC Program-purchased vaccine only to a child (<19 years of age) who: (a) is on Medicaid or Medicaid Managed Care; (b) is on NJ FamilyCare Plan; (c) has no health insurance; (d) is an American Indian or Alaskan Native; or (e) has health insurance that does not pay for the vaccine (applicable only to vaccines administered by a FQHC).
2. I will administer NJVFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in NJVFC resolutions.
3. I will maintain all records related to the NJVFC Program for a minimum of three years, unless state law requires a longer duration. Release of such records will be bound by the privacy protection of Federal Medicaid law.
4. If requested, I will make such records available to the State or the U.S Department of Health and Human Services (HHS).
5. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the HHS Advisory Committee on Immunization Practices (ACIP) and included in the NJVFC Program, unless (a) in making a medical judgement in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular recommendation is not in compliance with the laws of my State, including State laws relating to religious or other exemptions. *
6. I will provide the most current Vaccine Information Statement (VIS) at every visit and will maintain records in accordance with the National Childhood Vaccine Injury Act.
7. I will report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. I will immunize eligible children with NJVFC supplied vaccine at no charge to the patient for the vaccine.
9. I will not charge a vaccine administration fee to the non-Medicaid NJVFC-eligible children that exceeds the administration fee cap of $24.23. I will accept the reimbursement for immunization administration set by the New Jersey State Medicaid agency or the contracted Medicaid health plans.
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 requirements for ordering vaccine, accounting for vaccine usage and will operate within the NJVFC Program in a manner which will avoid fraud and abuse.
12. I or the State may terminate this agreement at any time for personal reasons or for failure to comply with these requirements. I agree to return all unused viable and unviable vaccine to the NJVFC Program following Program procedures.
13. I will be required to replace, dose-for-dose, all NJVFC vaccine lost due to mismanagement within the provider's practice.

****The ACIP Immunization Schedule is compatible with the AAP recommendations.***

By entering my name below, I acknowledge and accept the above IMM-25 Provider Enrollment Agreement

Name of Lead Physician (Print)	Signature of Lead Physician	Date

FOR STATE USE ONLY:	Date Certified for NJVFC	PIN Number

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PROVIDER PROFILE: ADULTS

A. PIN Number	B. Site Medicaid ID No. ***(Mandatory)***	C. New Provider? ☐ Yes ☐ No
D. Site Name		E. Tax ID Number

F. Name of Contact Person (Last, First)

G. Vaccine Delivery Address **(NO PO BOX OR HOME ADDRESS)**

Street Address: _____

City, State, Zip: _____ County: _____

H. Office Hours (Days/Hours):

M: _____ **T:** _____ **W:** _____ **TH:** _____ **F:** _____

I. Telephone Number ( )	J. Fax Number ( )	K. Business Email Address ***(Mandatory)***

L. Type of Facility (Check Only One):

10 ☐ Public Health Department
16 ☐ Other Public
12 ☐ Public Hospital
22 ☐ Private Hospital
25 ☐ Federally Qualified Health Center (FQHC)

NOTE: The following information must be based on data and not estimates. Please document the data source for this information in the boxes provided in Section O.

	19-29 Yrs.	30-39 Yrs.	40-59 Yrs.	60+ Yrs.	Total
M. For a 12-month period, project the **total number of adults** who will receive vaccinations at your practice/clinic:					

N. Of the numbers entered in Section M, estimate how many are expected to be eligible because they are:

(Note: Do not count an adult twice or in more than one of the categories listed below):

	19-29 Yrs.	30-39 Yrs.	40-59 Yrs.	60+ Yrs.	Total
Enrolled in Medicare/No Part D					
Uninsured/Underinsured					
317 (Only available to local health departments)					
Total Eligible Adults					

O. Type of data used to determine projected number of adults served in the two (2) Sections above:

A ☐ Doses Administered Data
B ☐ Medicare Claims Data
C ☐ Provider Encounter Data
D ☐ Registry Data
E ☐ Other (Specify): _____

P. In case of a power failure, is a back-up generator on site? ☐ Yes ☐ No If Yes, submit documentation.	Is there a back-up plan for storage of vaccines? ☐ Yes ☐ No If Yes, submit plan.

Name of Lead Physician (Print)	Signature of Lead Physician	Date

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LICENSED MEDICAL PROVIDERS LIST

Site Name		PIN Number
Site Medicaid ID Number ***(Mandatory)***	Telephone Number	Fax Number

Name of Practitioner ***(Last, First, MI)***	**Practitioner's Medicaid Number** ***(REQUIRED)***	**Medical License Number** ***(REQUIRED)***	**Title** ***(MD, DO, CMA, RN, etc.)***	**Practitioner's Date of Birth ***
1.				
2.				
3.				
4.				
5.				

List Associated Medical Offices:

Name		NJ VFC PIN
Street	City	NJ Telephone Number
Name		NJ VFC PIN
Street	City	NJ Telephone Number
Name		NJ VFC PIN
Street	City	NJ Telephone Number
Name		NJ VFC PIN
Street	City	NJ Telephone Number

* The practitioner's birth date enables the NJ VFC program to check the Department of Health and Human Services (HHS) Office of Inspector General (OIG) "List of Excluded Individuals/Entities" who are not permitted to participate in Federally-funded health care programs.

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VARICELLA / MMRV STORAGE QUESTIONNAIRE

Site Name	PIN Number
Mailing Address **(No PO Box OR Home Address)** ***(Mandatory)***	Telephone Number ( )
City, State, Zip Code	Fax Number ( )
Name of Contact Person	Business Email Address ***(Mandatory)***

Office Days/Hours (Enter office hours below for each day; enter hours when the office is open.)

Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***

Refrigeration/Storage

Dorm size refrigerators are NOT acceptable for storing Varicella/MMRV!

1. Type of refrigeration unit:
   - ☐ Combination (refrigerator and freezer in one unit)
   - ☐ Stand Alone (unit is a refrigerator OR a freezer)
2. Is the refrigerator frost-free? ..... ☐ Yes ☐ No
3. Is the freezer frost-free? ..... ☐ Yes ☐ No
4. Is the temperature monitored in the refrigerator/freezer? ..... ☐ Yes ☐ No
5. How often is the temperature monitored on the refrigerator/freezer?
   ☐ Twice Daily ☐ Weekly ☐ Every 3 Months
   ☐ Once Daily ☐ Monthly ☐ Every 6 Months
6. If you have a combination refrigerator/freezer, is the freezer compartment sealed and outside the refrigerator? ..... ☐ Yes ☐ No
7. Is vaccine transported outside the building from your main refrigerator/freezer? ..... ☐ Yes ☐ No
8. Does the freezer maintain a temperature of 5 degrees Fahrenheit or less for frozen vaccine? ..... ☐ Yes ☐ No
9. Do you have NIST-Certified, calibrated thermometers in the refrigerators and freezers? ..... ☐ Yes ☐ No

Name of Person Recording the Temperatures (Print)	
Lead Physician Signature	Date