

Provider Profile

PIN: _____

Connecticut Vaccines For Children Program

All public and private health care providers who receive vaccine from the Connecticut Vaccines for Children Program (**VFC**) must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Immunization Program will keep this record on file with the **SIGNED "Provider Agreement"** on the back of this page. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the status of the facility changes. Complete one form for each office/site/satellite.

Federal Employer Tax ID: _____

Group Medicaid Billing Number: _____

Please provide the following information for all personnel who administer vaccines.

Physician	_____	CT License #	_____	Medicaid Billing #	_____
Physician	_____	CT License #	_____	Medicaid Billing #	_____
Physician	_____	CT License #	_____	Medicaid Billing #	_____
RN, APRN	_____	CT License #	_____	Medicaid Billing #	_____
Other	_____	Other License #	_____	Medicaid Billing #	_____

Shipping Address:

Facility/Provider Name: _____

Contact Person: _____

Street Address (no P.O. Boxes): _____

City, State, Zip: _____

+ Phone # _____ Fax # _____

+ If possible, we would like this number to be a direct line to the person who orders the vaccines.

Office Days and Hours: _____

Indicate the Type of Facility (please check one only):

- _____ 10 Public Health Department
- _____ 12 Public Hospital
- _____ 16 Other Public (please specify: _____)
- _____ 15 Federally Qualified Health Center (FQHC) or federally funded Rural Health Clinic
- _____ 20 Private Practice (Individual or Group)
- _____ 22 Private Hospital
- _____ 24 Other Private (Please specify _____)

	Birth to 2 yrs	3-6 yrs	7-18 yrs	> 18 yrs	Total
Total Patients in practice needing state supplied immunizations (by age):	_____	_____	_____	_____	_____

Breakdown how many of the children you entered above into the categories below:
(Please do not count a child in more than one category or use percentages.)

	Birth to 2 yrs	3-6 yrs	7-18 yrs	Total
31 Enrolled in Medicaid	_____	_____	_____	_____
32 Without Health Insurance	_____	_____	_____	_____
33 American Indian or Alaskan Native	_____	_____	_____	_____
*44 Underinsured	_____	_____	_____	_____

* (Complete **44 Underinsured** only if your facility is an FQHC, an agent of an FQHC or an RHC (see 15 above)
These numbers must be entered in order to receive vaccines. New providers should give an estimate.
PLEASE remember to sign the **"Provider Agreement"** on the back of this page.

In the future, we may use e-mail for some communications; please give us the e-mail address for your facility.

_____ @ _____