

MnVFC Annual Provider Agreement 2012

Medical/Agency Director: <i>(must have prescription writing privileges and be authorized to sign for provider/clinic/corporation)</i>		
Last:	First:	
Medical/Agency Director's Title:		
Medical License #:	Medicaid Provider #:	
Clinic/Practice/Agency:		PIN:
Mailing Address:		
City:	State:	Zip:

To receive vaccines at no cost through the Minnesota Vaccines for Children program (MnVFC), which includes the federal Vaccines for Children program (VFC) and state procured vaccine, on behalf of myself and all clinic staff for whom I am the medical/agency director or equivalent:

1. I agree to screen each individual in need of immunizations to determine eligibility for the MnVFC program at each visit before administering vaccine. I will administer MnVFC vaccine only to patients identified as eligible to receive MnVFC vaccine, using the appropriate eligibility screening form.
2. I will comply with the appropriate immunization schedule, dosage, and contraindications established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:
 - a) in making a medical judgment in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or
 - b) the patient or their parent/guardian declines particular immunizations or
 - c) the requirement contradicts state law, including laws pertaining to religious and other exemptions.
3. I will not charge for the cost of MnVFC vaccine.
4. I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the administration fee cap of \$14.69 per vaccine dose. For Medicaid VFC-eligible children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
5. I will not deny administration of any vaccine received from the MnVFC program to a patient due to the inability of a child's parent or guardian, or individual of record to pay the administration fee.
6. I will distribute the most current Vaccine Information Statement (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Reporting System (VAERS).
7. I will retain the written responses of parents/guardians/patients about MnVFC eligibility status and all records related to the MnVFC program for a period of three years. If requested, I will make such records available to the Minnesota Department of Health or the Department of Health and Human Services. Release of such records will be bound by applicable federal and state laws.

10/2011: This replaces all previous versions and is valid until replaced by the MnVFC program.

8. I will comply with requirements for vaccine ordering, vaccine management, and vaccine accountability which include the following:
 - a) Maintain appropriate refrigerator/freezers and thermometers
 - b) Manage MnVFC vaccine inventory efficiently
 - c) Receive and store vaccine according to written plan
 - d) Post an anaphylaxis protocol
 - e) Have a written emergency plan for power outages
 - f) Complete and submit MnVFC provider agreement and annual report form by November 30 of each year
 - g) Complete and submit semi-annual doses administered reports for doses given to adult patients (≥ 19 years of age) within 60 days of the end of the reporting period
 - h) Replace vaccine that has been wasted due to negligence.
9. I agree to operate within the MnVFC program guidelines in a manner intended to avoid fraud and abuse.
10. I will permit visits to my facility by authorized representatives of the MnVFC program or Department of Health and Human Services to review compliance with MnVFC policies and procedures including, but not limited to: patient chart review, vaccine handling and storage, and other applicable immunization subjects. Release of such records will be bound by the privacy protection of the federal Medicaid law and falls within HIPAA Privacy Rules 45 CFR § 164.512(b).
11. I understand that I or the state may terminate this agreement at any time for personal reasons or failure to comply with these requirements. I understand that if this agreement is terminated, I must return to the MnVFC program all unused (viable and non-viable) vaccine that has been provided by the state. Furthermore, I understand I must participate in MnVFC as required by state law (Minnesota Statutes, Section 256B.0625, Subd. 39) in order to be compensated for vaccine I provide to Medicaid-eligible patients.
12. I agree to submit with this agreement a list of all medical providers associated with this clinic/corporation and their medical license numbers.

I certify that I have read and agree to the requirements listed above pertaining to participation in the Minnesota Vaccines for Children program and the federal Vaccines for Children program.

Clinic Administrator Signature:	Date
Medical/Agency Director Signature: <i>(authorized to sign for provider/clinic/corporation; must have prescription writing privileges: MD, DO, ND, NP, PA, CNM)</i>	Date

PLEASE RETURN THIS FORM BY MAIL OR FAX TO:



Minnesota Department of Health
MnVFC Program
P.O. Box 64975
St. Paul, Minnesota 55164-0975
Fax: 651-201-5501



Additional Providers Within The Practice

Last Name, First, MI	Medical License No.	Title (MD,DO,ND,NP,PA,CNM) <i>(Provider must have prescription writing privileges)</i>	Specialty (Peds, Family Med, GP, HO (Hlth Ofcr), Other (specify))

Medicaid Provider No.			
Last Name, First, MI	Medical License No.	Title (MD,DO,ND,NP,PA,CNM) <i>(Provider must have prescription writing privileges)</i>	Specialty (Peds, Family Med, GP, HO (Hlth Ofcr), Other (specify))

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Medicaid Provider No.			



MnVFC Program
P.O. Box 64975
St. Paul, Minnesota 55164-0975
651-201-5522 or 1-800-657-3970
Fax: 651-201-5501
www.health.state.mn.us/vfc

