TEXAS Department of State Health Services

Immunization Branch
Vaccine Operations Group

Texas Vaccines for Children Provider Agreement Worksheet - 2015

Instructions for Completing the Provider Agreement

The Texas Vaccines for Children (TVFC) Program has prepared this worksheet to aid providers in completing the 2015 TVFC re-enrollment process. Listed below are all fields TVFC providers are required to complete when filling out the online Provider Agreement.

The first column shows the field in the online Provider Agreement. The second column provides a description of how to complete the field. The third column is available for provider to use to document their responses prior to logging on to the survey to complete the online Provider Agreement.

This worksheet is not required; however it is a useful tool available to all re-enrolling providers.

FIELD	DESCRIPTION	PROVIDER INFORMATION
Provider Agreement		
VFC PIN	**REQUIRED** Enter your six digit TVFC PIN	
Facility Name	**REQUIRED** Enter the name of the facility	
Facility Address		
Street Address	**REQUIRED** Enter the street address of facility	
Street Address 2	Enter additional address information: e.g., suite number	
City	**REQUIRED** Enter the city of facility	
Zip	**REQUIRED** Enter the zip code of the facility	
County	**REQUIRED** Enter the county of facility	
Shipping Address (OPTIONAL)		
Shipping Address	Enter the shipping address if it differs from the facility address	
Street Address	Enter the street address for shipping	
Street Address 2	Enter additional address information: e.g., suite number	
City	Enter city for shipping	
Zip	Enter the zip code for shipping location	
County	Enter the county of shipping location	

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Medical Director or Equivalent		
Last Name	**REQUIRED** Enter the last name of the medical director	
First Name	**REQUIRED** Enter the first name of the medical director	
Title	**REQUIRED** Enter the title of the medical director (MD, NP, PA, DO, etc.)	
Specialty	**REQUIRED** Enter the specialty of the medical director (i.e. pediatrics, etc.)	
License Number	**REQUIRED** Enter the TX medical license of the medical director (e.g. A1234)	
National Provider ID	**REQUIRED** Enter the national provider identifier number (NPI # 10-digit number)	
VFC Primary Coordinator		
Last Name	**REQUIRED** Enter the last name of the Primary Coordinator	
First Name	**REQUIRED** Enter the first name of the Primary Coordinator	
Title	**REQUIRED** Enter the title of the primary coordinator (i.e. MD, MA, office manager, etc.)	
Telephone Number	**REQUIRED** Enter the telephone number of the Primary Coordinator	
Email Address	**REQUIRED** Enter the email address of the Primary Coordinator	
VFC Back-Up Coordinator		
Last Name	**REQUIRED** Enter the last name of the Back-up Coordinator	
First Name	**REQUIRED** Enter the first name of the Back-up Coordinator	

Title	**REQUIRED** Enter the title of the Back-up Coordinator (i.e. MD, MA, office manager, etc.)	
Telephone Number	**REQUIRED** Enter the telephone number of the Back-up Coordinator	
Email Address	**REQUIRED** Enter the email address of the Back-up Coordinator	
Required Training		
Primary coordinator	**REQUIRED** Check the boxes for the appropriate answer to the questions	
Back-up coordinator	**REQUIRED** Check the boxes for the appropriate answer to the questions	
Providers Practicing at this Facility	Enter all licensed health care providers that have prescribing authority. (i.e. MD, DO, NP, RPH, etc.)	
Name	**REQUIRED** Enter the name of the provider (first name, last name).	
Title	**REQUIRED** Enter the title of the provider (i.e. MD, DO, NP, etc)	
License Number	**REQUIRED** Enter the provider's valid Texas medical license (e.g. A1234)	
National Provider ID	**REQUIRED** Enter the provider National provider identifier number (NPI# 10-digit number)	
Provider Agreement		
Name	**REQUIRED** Enter the name of the medical director of the facility	
Today's Date	**REQUIRED** Enter today's date	
Facility Type (Drop-down)		
Private Choice	**REQUIRED** Select the type of private facility this facility is. If it is a public facility select "Not Applicable, We are a public facility	

Public Choice	This choice will only show if "Not applicable" was chosen on the previous drop down box. Select the type of public facility this facility is. **REQUIRED if "Not applicable" is selected in the previous drop down menu**	
Vaccines Offered (All, Specialty)		
Selection	**REQUIRED** Select whether you facility offers all ACIP vaccines or select vaccines. Choose "All ACIP Recommended Vaccines" unless you have been approved by the Immunization Program as a	
Select Vaccines Offered by Specialty Provider	Question is available only if "offers select vaccines" is chosen. Select each vaccine your specialty facility offers. **REQUIRED only if previous answer selected is "Select vaccines offered by Specialty Provider"**	
Provider Population		
Enrolled in Medicaid	**REQUIRED** Enter number of children in this category who received VFC vaccine in your practice by age group: • <1 YEAR • 1-6 YEARS • 7-18 YEARS	
No Health Insurance	**REQUIRED** Enter number of children in this category who received VFC vaccine in your practice by age group: • <1 YEAR 1 6 YEARS	

American Indian /Alaskan Native	**REQUIRED** Enter number of children in this category who received VFC vaccine in your practice by age group: • <1 YEAR	
Underinsured in FQHC/ RHC or Deputized Facility	**REQUIRED** Enter number of children in this category who received VFC vaccine in your practice by age group: • <1 YEAR • 1-6 YEARS • 7-18 YEARS **Only FQHC/ RHC/ & Deputized Facilities should enter underinsured population numbers in this row**	
Total VFC	**REQUIRED** **Total each column in the VFC eligible section**	
Insured (private pay/ health insurance covers vaccines)	**REQUIRED** Enter number of children in this category who received non-VFC vaccine in your practice by age group: • <1 YEAR • 1-6 YEARS • 7-18 YEARS	
Other underinsured	**REQUIRED** Enter number of children in this category who received non-VFC vaccine in your practice by age group: • <1 YEAR • 1-6 YEARS • 7-18 YEARS **All providers except FQHC/RHC/ & Deputized facilities should use this row for underinsured reporting**	

Children's Health Insurance Program (CHIP)	**REQUIRED** Enter number of children in this category who received non-VFC vaccine in your practice by age group: • <1 YEAR • 1-6 YEARS	
Total Non-VFC	**REQUIRED** **Total each column in the non-VFC eligible section**	
Total Patients	**REQUIRED** **Enter the sum of total VFC + total non-VFC**	

FINAL STEP: After submitting the online Provider Agreement, providers must print and sign the document. Providers must fax or email a copy of the responses to their responsible entity (DSHS HSR or LHD).