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State of Louisiana

Louisiana Department of Health
Office of Public Health

February 8, 2019

TO: Vaccines for Children Providers

FROM: Stacy Hall, RN MSN
Immunization Program Director

Adrienne Mercadel Whitney, MPH
Vaccine for Children Distribution & Procurement Manager

SUBJECT: **Recertification Needed to Continue as a VFC Provider in 2019**

On behalf of the Department of Health & Hospitals, Office of Public Health, we would like to thank you for being a Vaccines for Children (VFC) provider in 2018. Your commitment and participation has made it possible for many low income or uninsured Louisiana children to receive vaccines in their medical home.

The national VFC Program requires an annual recertification process each year. **To continue as a VFC provider, you will need to complete your 2018 re-enrollment online within LINKS by March 15, 2019.**

Before you begin your online renewal, please review the VFC Provider Recertification cover letter and Instruction document located under the VFC/VOMS section on the homepage of LINKS.
The guide includes important information and instructions to help you complete your agreement.
Please use the guide to help you work through the three screens needed to complete the agreement.

Most of the information you will need to complete your 2019 provider agreement is preloaded in the system. You will see it when you open the agreement. Please review the information and make sure it is correct. Update your information if it has changed.

You will need to gather some additional information before logging on to LINKS. Gathering the information ahead of time will save you time and help the process go smoothly.

- **Facility details-** Verify the physical address, immunization delivery address, and mailing address for your practice
- **Contact details –** Verify and edit the names, email addresses, telephone and fax numbers for the following: signatory, primary, and back-up immunization coordinator.
    - Make sure emails are correct. Include phone and fax numbers for all contacts even if they are the same.
    - Complete the training completion fields under the relevant contacts.

- **Annual training requirements-** All vaccine coordinators must have VFC training each year. This generally means taking CDC's "You Call The Shots" or "Keys to Storage and Handling Your Vaccines" modules. Vaccine Coordinators may also count a recent VFC Site Visit for the training requirement if they were present. Enter the type of training provided for your vaccine coordinators.

- **Shipping details –** Verify the days of the week and core business hours that staff is available to receive immunizations. Include closure for lunch.
- **Immunization Offered –** Most providers will select "All ACIP Recommended Immunizations." If a provider is a specialty provider, (i.e. flu only clinics), they may check "Offers Selected Immunizations. If you are a specialty provider, select the reason and mark the immunizations provided.
- **Physician/Vaccinator details –** Verify the name, designation, and Louisiana State professional medical license number, Provider Medicaid Number, and National Provider ID (NPI) is required for the physician signing the agreement.

Completing the recertification process could take 20 minutes or longer depending on how many physicians are active with your practice. You must complete all required fields in each section of the agreement to proceed to the next screen. The information you enter will be saved as you complete each screen. If you need to stop before you have completed the agreement, be sure to save the screen you are on so you can come back later and complete the process. You must complete all three screens of the online agreement before you submit it to the state. **To begin the recertification process, click on the VFC/VOMS icon on the LINKS home page for instructions.**

After you submit the online agreement, you must print the PDF Full, sign, and keep the original agreement on file at your clinic. The provider licensed in the State of Louisiana to prescribe immunizations, responsible for making decisions about the clinic, its operations, must sign all signature forms. **We will not accept signatures from any other office personnel.** Mail or fax to us the PDF Signature page (5) and the completed Annual Provider Training certificates of your primary and back-up coordinators. If we do not have all certificates and the signature page, your re-enrollment is considered incomplete. Please remember to put your VFC pin number on all the pages.

To assure immunization ordering is not disrupted; DO NOT WAIT UNTIL THE LAST MINUTE TO COMPLETE YOUR ONLINE RE-ENROLLMENT!

We cannot approve your agreement until we review the submitted information. If we do not approve your agreement by March 15, 2019, you will not be able to order immunizations.

If you have any questions concerning completion of these forms, please contact your Regional Immunization Consultant.

Page 1:
Provider Agreement

FIELD	DESCRI TION	Information for each facility
VFC PIN	PIN pre-populates based on user login. New providers will have a temporary PIN assigned	
FACILITY NAME	Required	
Agreement signatory	Required Name of the medical director or equivalent that will be signing the agreement	
Agreement signatory title	Required Title of the medical director or equivalent that will be signing the agreement (MD, APN, FNP, etc.)	

FACILTY ADDRES		
street address	**Required** **street address of facility**	
street address 2	additional address information: e.g., suite number	
City	**Skip to Zip Code**	
State	**Skip to Zip Code**	
Parish	**Skip to Zip Code**	
zip code	**Required** **Entering a zip code will populate city, state, and county.**	
Vaccine Delivery Address		
Check if vaccine delivery address is the same as facility address	Select check box if delivery address is same as FACILITY address	
street address	**Required** **street address of facility**	
street address 2	additional address information: e.g., suite number	
City	**Skip to Zip Code**	
VFC PIN	**PIN pre-populates based on user login. New providers will have a temporary PIN assigned**	
FACILITY NAME	**Required**	
Agreement signatory	**Required** **Name of the medical director or equivalent that will be signing the agreement**	
Agreement signatory title	**Required** **Title of the medical director or equivalent that will be signing the agreement (MD, APN, FNP, etc.)**	
FACILTY ADDRES		
street address	**Required** **street address of facility**	
street address 2	additional address information: e.g., suite number	
City	**Skip to Zip Code**	
State	**Skip to Zip Code**	
parish	**Skip to Zip Code**	
zip code	**Required** **Entering a zip code will populate city, state, and county.**	
Vaccine Delivery Address		
Check if vaccine delivery address is the same as facility address	Select check box if delivery address is same as FACILITY address	

All ACIP recommended vaccines, or offers selected vaccines	**Required Select the appropriate radio button based on the vaccine offered by yourfacility**	**Choose "All ACIP Recommended Vaccines" unless you have been approved by the Immunization Program as a specialty provider or only serve adolescents.**
A defined population due to practice specialty	Question is available only if "offers select vaccines" ischosen. Select if your facility only serves a specialty group of patients. Enter specifics in comment box, e.g., Ob/Gyn.	
A specific age group within the general population of children aged 0-18 years.	Question is available only if "offers select vaccines" is chosen. Select this if your facility only serves a specific age group and enter the age group served in comment box.	
Select vaccines offered by a specialty provider	Question available if selected "offers select vaccines". Select check boxes of vaccines offered by theclinic.	
Shipping Information (refer to user guide for illustrations)		
Days of operation	**Required**	
HOURS OF OPERATION	**Required** **Adjust hours based on available to receive shipments as needed Please include if closed for lunch**	
FACILITY TYPE	**Required - select from dropdown list.**	

Page2:AuthorizedProvidersAdd/Editfielddescriptions

List all the authorized providers within the practice (providers with prescribing privileges).

FIE D	DESCRI TION	
Last name **Name must be entered exactly as it appears on the provider's license.**	**Required** **Enter last name as it appears on the provider's license.**	
FIRST NAME **Name must be entered exactly as it appears on the provider's license.**	**Required** **Enter first name as it appears on the provider license.**	
TITLE	**Required** **Select title from dropdown list**	
SPECIALITY	**Required** **Select specialty from drop down:**	
ACTIVE WITH THISPRACTICE	**Required - Select appropriate radio button**	
MEDICAL LICENSE NUMBER	**Required** **ENTER MEDICAL LICENSE NUMBER OF PROVIDER**	

Provider Medicaid Number	**Required**	
NPI NUMBER	**Required** **ENTER NPI NUMBER OF PROVIDER**	
MEDICAL DIRECTOR OR EQUIVILANT	SELECT RADIO BUTTON - **Required** The selected provider will be listed as the signatory party for the provider agreement.	

Page 3: Provider/Practice Profile field description

VFC VACCINE ELIGIBLE CATEGORY	Children who receive VFC vaccine in past 12 months by age group	
Enrolled in Medicaid	**Required** **Enter number of children in this category who received VFC vaccine in your practice by age group.**	
NO HEALTH INSURANCE	**Required** **Enter number of children in this category who received VFC vaccine in your practice by age group.**	
AMERICAN INDIAN/ALASKA NATIVE	**Required** **Enter number of children in this category who received VFC vaccine in your practice by age group.**	
UNDERINSURED IN FQHC/RHC	**Required** **Enter number of children in this category who received VFC vaccine in your practice by age group.**	
TOTAL (COLUMN	AUTOMATICALLY CALCULATES	
TOTAL VFC (ROW)	AUTOMATICALLY CALCULATES	
NON -VFC ELIGIBLE CATEGORY	Children who receive non-VFC vaccine, by age	
INSURED (health insurance)	Enter number of children in this category who received non-VFC vaccine in your practice by age group.	
CHILDRENS HEALTH INSURANCE PROGRAM	Enter number of children in this category who received non-VFC vaccine in your practice by age group.	
TOTAL (COLUMN	AUTOMATICALLY CALCULATES	
TOTAL NON-VFC ROW)	AUTOMATICALLY CALCULATES	
TOTAL PATIENTS	AUTOMATICALLY CALCULATES	
WHAT DATA SOURCE WAS USED?	**Required** **Select data source(s) for the numbers of children you provided in each eligibility category (select all that apply)**	

FINAL STEP: After submitting your online agreement, you will be able to view and print a PDF of your agreement. You will need to print the signature page (5) and send to the Louisiana Immunization VFC Program. See the Walkthrough Guide for more detailed instructions and screenshots.