Provider Profile Adjustment

VFC PIN / USIIS ID

Facility Name: _____

Completed by (please print): _____ **Date:** _____

Medical Director or Equivalent Signature: _____

A. VACCINES OFFERED (select only one):

☐ All ACIP Recommended Vaccines for children 0 through 18 years of age.

☐ Offers Select Vaccines **(This option is only available for facilities designated as Specialty Providers by the VFC Program).**

Select Vaccines Offered by Specialty Provider:

❑ DTaP	❑ HPV	❑ Pneumococcal Conjugate	❑ TD
❑ Hepatitis A	❑ Influenza	❑ Pneumococcal Polysaccharide	❑ Tdap
❑ Hepatitis B	❑ Meningococcal Conjugate	❑ Polio	❑ Varicella
❑ HIB	❑ MMR	❑ Rotavirus	❑ Other, specify:

B. Provider population based on patients anticipated during the remaining calendar year. *Report the estimated number of children who will receive vaccinations at your facility, by age group. Only count a child once based on the status at the last immunization visit. Information should reflect only the reason for adjustment.*

VFC Vaccine Eligibility Categories	**# of children who will receive VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
Enrolled in Medicaid				
No Health Insurance				
American Indian/Alaska Native				
Underinsured in FQHC/RHC or deputized facility				
Total VFC:				
Non- VFC Vaccine Eligibility Categories	**# of children who will receive non-VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
Insured (private pay/health insurance covers vaccines)				
Children's Health Insurance Program (CHIP)				
Total Non-VFC:				
Total Patients (must equal sum of Total VFC + Total Non-VFC)				

Type of data used to determine projections:

❑ Benchmarking	❑ Doses Administered	❑ Other (must describe):
❑ Medicaid Claims Data	❑ Provider Encounter Data	
❑ IIS (USIIS)	❑ Billing System	

Reason for population adjustment:

❑ Adding clinician	❑ Change in VFC eligible population
❑ Removing clinician	❑ Other (must describe):

C. If applicable, list below any new or removed licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have/had prescribing authority.

NEW PROVIDERS PRACTICING AT THIS FACILITY (attach additional pages if necessary)				
Provider Name	**Title**	**License No.**	**Medicaid/NPI No.**	**EIN**

REMOVED PROVIDERS PRACTICING AT THIS FACILITY (attach additional pages if necessary)				
Provider Name	**Title**	**License No.**	**Medicaid/NPI No.**	**EIN**

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program. A Provider Profile Adjustment should be completed with major changes to the provider practice, including adding or removing a practitioner and changes to VFC eligible population. ***A copy of this completed document is considered the same as the original.***

Send emailed form to:
immunize@utah.gov
Send faxed form to:
(801) 538-9440

UTAH VFC PROGRAM USE ONLY

Date Approved: _____ Approved By: _____

VTrckS Entry Date**:** _____ VTrckS Entry By: _____