Adult Vaccine Program (AVP)
Provider Enrollment Agreement

FACILITY INFORMATION

Facility Name:			Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official AVP-registered health care provider signing the agreement must be a practitioner authorized to administer vaccines under state law, who will also be held accountable for compliance by the entire organization and its AVP providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:		Title:
Specialty:	License No:	Medicaid or NPI No:
Employer Identification Number:	Email:	

VACCINE COORDINATORS

Vaccine Coordinator Name:	
Telephone:	Email:
Vaccine Coordinator Name:	
Telephone:	Email:

PROVIDERS PRACTICING AT THIS FACILITY

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN (Optional)

PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or practice administrator or equivalent:

1.	I will screen patients and document eligibility status at each immunization encounter for AVP eligibility and administer AVP-purchased vaccine by such category only to people who are: a) 19 years of age or older, b) Wyoming residents*, and c) Uninsured or underinsured. a. *Underinsured is defined as an individual who has commercial (private) health insurance, but the coverage does not include the vaccine to be administered, or an individual whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the individual is categorized as underinsured.* *Residency in Wyoming is only applicable for the Adult Hepatitis Vaccine Program. All other publicly supplied vaccines administered should be administered regardless of residency as long as all other eligibility criteria is met.
2.	I will maintain all records related to the AVP program for a minimum of three years, or longer if required by state law, and upon request make these records available for review. AVP records include, but are not limited to, eligibility screening and documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
3.	I will immunize eligible individuals with publicly-supplied vaccine at no charge to the patient for the vaccine.
4.	I will not charge a vaccine administration fee to AVP-eligible patients that exceeds the administration fee cap of $21.72 per dose. I will not deny administration of a publicly purchased vaccine to an established patient because the individual of record is unable to pay the administration fee.
5.	I will not send unpaid vaccine administration fees to any collection agency if the individual of record is unable to pay the administration fee.
6.	I will distribute the current Vaccine Information Statement (VIS) each time a vaccine is administered and report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
7.	I will comply with the requirements for vaccine management including: a) Not storing vaccine in dormitory-style units at any time; b) Store vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Wyoming Immunization Unit storage and handling recommendations and requirements; and c) Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.

8.	I agree to operate within the AVP program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the AVP program: **Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
9.	I will participate in AVP program compliance site visits, including unannounced visits and other educational opportunities associated with AVP program requirements.
10.	I agree to replace vaccine purchased with state funds that are deemed non-viable due to provider negligence on a dose-for-dose basis.
11.	I will use the Wyoming Immunization Registry (WyIR) for the following activities: a) inventory management of state-purchased vaccines b) vaccine transfers c) vaccine ordering d) reporting all doses administered, including privately-purchased vaccine doses
12.	I will document AVP-eligibility as "Adult State" in the WyIR.
13.	I understand this facility or the Wyoming Immunization Unit may terminate this agreement at any time. Upon termination of this agreement, I will properly return any unused state-supplied vaccine as directed by the Wyoming Immunization Unit.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Adult Vaccine Program enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date: