# NORTH CAROLINA BRIDGE ACCESS PROGRAM PROVIDER 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 North Carolina Bridge Access Program 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 North Carolina Bridge Access Program providers with the responsible conditions outlined in the provider enrollment agreement. For the purposes of this agreement, a vaccine is defined as any vaccine or vaccine-like product recommended by the Advisory Committee on Immunization Practices (ACIP). The individual listed here must sign the provider agreement.* | | |
| Last Name, First, MI: | | Title: |
| Specialty: | NC License No: | NC Medicaid or NPI No: |
| Employer Identification Number: | | Email: |

| BRIDGE ACCESS PROGRAM VACCINE COORDINATOR | |
|---|---|
| **Primary Vaccine Coordinator Name:** | |
| Telephone: | Email: |
| Completed annual training:<br>○ Yes ○ No | Type/date of training received: |
| **Back-Up Vaccine Coordinator Name:** | |
| Telephone: | Email: |
| Completed annual training:<br>○ Yes ○ No | Type/date of training received: |

**PROVIDERS PRACTICING AT THIS FACILITY** *(additional spaces for providers at end of form)*

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

| Provider Name | Title | NC License No. | NC Medicaid or NPI No. | EIN (Optional) |
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## PROVIDER AGREEMENT

***To receive publicly funded COVID-19 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 annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of patients served changes or 2) the status of the facility changes during the calendar year. |
| **2.** | I will screen patients and document eligibility status at each immunization encounter and administer publicly purchased and Bridge Access Program vaccines only to adults who are at least 19 years of age and meet one of the following categories:<br><br>a) Uninsured: A person who does not have health insurance.<br>b) Underinsured: A person who has health insurance, but the insurance does not include any vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not provide first-dollar coverage for vaccines. |
| **3.** | For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the North Carolina Bridge Access Program unless:<br>a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the person;<br>b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions. |
| **4.** | I will maintain all records related to the North Carolina Bridge Access Program for a minimum of three years, or longer if required by state law, and upon request make these records available for review. North Carolina Bridge Access Program records include, but are not limited to, North Carolina Bridge Program screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records. |
| **5.** | I will administer vaccine to eligible persons with publicly purchased vaccine at no charge to the patient for the cost of the vaccine. |
| **6.** | 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. |
| **7.** | I will distribute the current Vaccine Information Statements (VIS) or Emergency Use Authorization (EUA) fact sheet (if applicable) 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 Event Reporting System (VAERS). |
| **8.** | I will comply with the requirements for vaccine management including:<br>a) Ordering vaccine and maintaining appropriate vaccine inventories;<br>b) Not storing vaccine in dormitory-style units at any time;<br>c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet North Carolina Immunization Program storage and handling recommendations and requirements;<br>d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration |

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| **9.** | I agree to operate within the North Carolina Bridge Access 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 North Carolina Bridge Program:<br><br>**Fraud:** is 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.<br><br>**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. |
| **10.** | I will participate in the North Carolina Bridge Access Program compliance site visits including unannounced visits, and other educational opportunities associated with the North Carolina Bridge Program requirements as recommended by North Carolina Immunization Program. |
| **11a.** | I agree to submit vaccine administration data for all publicly purchased vaccines using Section 317 and state/local funds to the jurisdiction's Immunization Information System (IIS) in accordance with the North Carolina Immunization Program's regulations and reporting timelines. |
| **11b.** | I agree to submit vaccine administration data for all Bridge Access Program purchased vaccines to the jurisdiction's Immunization Information System (IIS) in accordance with CDC documentation and data requirements. |
| **12** | I agree to update Vaccines.gov to indicate Bridge Access Program vaccine availability and to make my profile public facing, according to CDC data guidance and timelines |
| **13.** | I understand this facility or the North Carolina Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the North Carolina Immunization Program. |

| | |
|---|---|
| ***By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the North Carolina Bridge 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: |

## ADDITIONAL PROVIDERS

**PROVIDERS PRACTICING AT THIS FACILITY** *(attach additional pages as necessary)*

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

| Provider Name | Title | NC License No. | NC Medicaid or NPI No. | EIN (optional) |
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## North Carolina Bridge Access Program
## Provider Profile Form

*All healthcare providers participating in the North Carolina Bridge Access Program must complete this form annually or more frequently if the number of eligible adults served changes or the status of the facility changes during the calendar year.*

**Date: ___ ___ /___ ___/ ___ ___ ___ ___** **Provider Identification Number#_____**

| **FACILITY INFORMATION** | | |
|---|---|---|
| **Provider's Name:** | | |
| **Facility Name:** | | |
| **Vaccine Delivery Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Telephone:** | **Email:** | |

**FACILITY TYPE (select facility type)**

| ☐ **Private Facilities** | ☐ **Public Facilities** | |
|---|---|---|
| ☐ Private Hospital | ☐ Public Health Department Clinic | ☐ Woman Infants and Children |
| ☐ Private Practice (solo/group/HMO) | ☐ Public Hospital | ☐ STD/HIV |
| ☐ Community Health Center | ☐ FQHC/RHC (Community/Migrant/Rural) | ☐ Family Planning |
| ☐ Pharmacy | ☐ FQHC Look-Alikes | ☐ Correctional Facility |
| ☐ Other_____ | ☐ Tribal Health Centers | ☐ Drug Treatment Facility |
| | ☐ Indian Health Services (IHS) Centers | ☐ Migrant Health Facility |
| | ☐ Community Health Center | ☐ Refugee Health Facility |
| | ☐ Tribal/Indian Health Services Clinic (Urban) | |
| | ☐ Other_____ | |

## PROVIDER POPULATION

Provider Population is based on patients seen during the previous 12 months. *Report the number of eligible adults who received vaccinations at your facility, by age group. Only count an adult <u>once</u> based on the status at the last immunization visit, regardless of the number of visits made. The following table documents the number of eligible adults who received publicly funded vaccines by category and the number of adults who received privately purchased vaccines.*

| **Publicly Funded Vaccine Eligibility Categories** | **# of individuals who received publicly purchased vaccines by age category** | | | |
|---|---|---|---|---|
| | **19 – 34 Years** | **35 – 49 Years** | **50+ Years** | **Total** |
| American Indian/Alaska Native[1] | | | | |
| No Health Insurance | | | | |
| Underinsured[2] | | | | |
| Incarcerated | | | | |
| **Total Publicly Funded Vaccine:** | | | | |
| **Privately Purchased Vaccine** | **# of individuals who received non-publicly purchased vaccines by age category** | | | |
| | **19 – 34 Years** | **35 – 49 Years** | **50+ Years** | **Total** |
| Insured (private pay/health insurance covers vaccines) | | | | |
| **Total Privately Purchased Vaccine:** | | | | |
| **Total Patients** (must equal sum of Total Publicly Funded + Total Privately Purchased) | | | | |

[1]American Indian and Alaska Native patients whose only source of healthcare is provided by an Indian Health Service, Tribal, or Urban Indian healthcare organization are not considered fully insured and may be vaccinated with 317-funded vaccines if the Indian Health Service, Tribal, or Urban Indian healthcare organization does not provide certain vaccines.

[2] A person who has health insurance, but the insurance does not include any vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not provide first-dollar coverage for vaccines.

## TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)

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

North Carolina Department of Health and Human Services (DHHS) - North Carolina Immunization Program (NCIP)

**NORTH CAROLINA BRIDGE ACCESS PROGRAM PROVIDERAGREEMENT - NCIR**

The purpose of this agreement is to allow _____to utilize the North Carolina Immunization Registry (NCIR) and fulfill all NCIP program requirements. The conditions of the agreement listed below are effective from the date the agreement is signed until renewal/reenrollment.

A. The lead physician signing this agreement shall be willing and able to:

1. Follow all NCIP program requirements, policies, and procedures, and participate in site visits and educational opportunities.
2. Be open at least four (4) consecutive hours on a day other than a Monday to receive state supplied vaccines.
3. Screen and document NCIP eligibility status with each immunization visit.
4. Administer vaccines provided through the North Carolina Immunization Program to eligible patients, following all Advisory Committee on Immunization Practices (ACIP) guidelines, according to the most relevant NCIP Coverage Criteria, and agree not to charge a third-party for the cost of vaccine.
5. Agree administration fees are per vaccine and not per antigen. Charge no administration fees for uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level.
6. Record the following for each dose of vaccine administered in the NCIR: (a) the manufacturer, (b) lot number, (c) date of administration, (d) administration site and route, (e) date the relevant current VIS was given, (f) date printed on the VIS, and (g) name, address, and title of the provider who administered the vaccine.
7. Provide a signed immunization record, at no charge, to the parent, guardian, or patient each time an immunization is given as specified in G.S. 130A-154 and when needed for schools, childcare facilities, colleges/universities, or wherever immunization records are required. Keep immunization records, either electronically or in paper form, according to the retention of medical records position statement of the North Carolina Medical Board.
8. Assume responsibility for all staff involved in the receipt, management, administration, and transport of vaccine.
9. Ensure all current and new staff are fully trained in vaccine ordering, storing, handling, administration, use of the NCIR, reporting guidelines, and transportation of vaccine in an emergency situation annually or more often as needed. Provide documentation (i.e. training roster or log sheet) of training participants and dates upon request of NCIP.
10. Assume accountability for all state supplied vaccines received by your practice/agency:
    a. Complete a physical inventory of all state-supplied vaccine at least weekly and properly reconcile with the NCIR at least monthly, with the recommendation of bi-weekly.
    b. Electronically record all vaccines into the NCIR at the time of administration or by the close of business the day the immunization is given.
    c. Follow the NCIP Borrowing Policy, including limiting borrowing of state supplied vaccines to rare occurrences, completing the Vaccine Borrowing Form for all borrowing instances, and replacing borrowed vaccine within 30 days. Planned borrowing of state supplied vaccine, including the use of state vaccine as a replacement system for a provider's privately purchased vaccine inventory is not permissible.
11. North Carolina Bridge Access Program including: use of appropriate storage units, use of data loggers with current calibration certificates, twice daily temperature documentation on a temperature log, daily MIN/MAX documentation, recording of doses administered in the NCIR and monthly reconciliation of inventory, etc.
12. Store vaccine on hand according to the most recent *NCIP Minimum Required Vaccine Ordering, Handling and Storage Procedures*.
13. The provider may be subject to the most current Financial Restitution Policy if vaccines are found to be wasted due to the provider's negligence and unreasonable failure to properly handle or store the vaccine.
14. Notify the Immunization Branch thirty days prior to a change in the lead physician who signed this agreement.
15. Notify the Immunization Branch immediately when there are changes to the vaccine coordinator or back-up vaccine coordinator, a change in the facility shipping and mailing address, or if the status of the individual signing the Provider Agreement changes.

B. With respect to the North Carolina Immunization Registry (NCIR), the Lead Physician signing this agreement shall:

1. Designate a minimum of two NCIR Administrators, with active, up-to-date internet email addresses, to ensure that the access level for each user does not exceed that individual's role in the agency and that access is only within the user's scope of work. Deactivate all users immediately should they leave your practice.
2. Require all users accessing NCIR under your authority to sign a *User Confidentiality Agreement* if they do not currently have one on file at your facility. The agreement must be made available to the Immunization Branch upon request.
3. As much as possible, assure that all patient names entered into the NCIR reflect the patient's true, legally-documented, complete name (e.g. from the birth certificate).
4. Ensure your facility has a contingency plan in place for use during periods of internal internet disruption and/or NCIR outages.
5. Acknowledge and agree that the NCIR does not make medical decisions and is not a substitute for competent, properly trained, and knowledgeable staff who bring professional judgment and analysis to the information presented by the software.

The Immunization Branch or provider may terminate this agreement at any time for personal reasons or failure to comply with conditions A.1 through B.5. The provider is required to comply with any additional North Carolina Bridge Access Program requirements as the CDC or NCIP may from time to time impose. Upon termination, the provider must properly store, handle, and return all viable, unused NCIP vaccine within 30 days of withdrawal. All suspensions of eligibility shall be in accordance with G.S. 130A. Individuals and facilities on the "List of Excluded Individuals and Entities" published by the Department of Health and Human Services Office of the Inspector General are prohibited from participating in federally-funded health care programs including the North Carolina Bridge Access Program.
I understand the terms of this agreement and agree to comply with this agreement and the rules promulgated by the State of North Carolina.

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Physician's Signature (DO NOT USE A STAMP) | Physician's Name (PRINT OR STAMP) | Federal Tax ID | Physician's NC Medical License # | Date |

**INSTRUCTIONS PURPOSE:**

This document constitutes a legal agreement under which the North Carolina Immunization Branch may provide vaccines to a private provider to immunize patients and access to the North Carolina Immunization Registry.

**PREPARATION:**

1. Prepare an original and a copy.
2. Print or type the practice's name.
3. The signature must be of a Medical Doctor or Doctor of Osteopathy licensed to practice medicine in North Carolina.
   a. The medical director in a group practice (or equivalent) must be authorized to administer pediatric vaccines under state law to sign the Provider Agreement.
   b. The provider signing the Provider Agreement on behalf of a multi-provider practice must have authority to sign on behalf of the entity. That provider will be held accountable for the entire organization's compliance, including site visit participation and educational requirements.
4. The physician's signature must be an original; a stamp is not acceptable.
5. The agreement shall be available for review by Immunization Branch personnel.

**DISTRIBUTION:**

1. **Please fill out this agreement and upload the signed document within the Bridge Agreement Survey.** Contact the Immunization Help Desk, Monday through Friday, 8 a.m. to 5 p.m. at 1-877-873-6247 if assistance is needed.

2. Retain a copy for your records.

**DISPOSITION:**

Completed (signed and dated) form must be retained until participation in the state-supplied vaccine program ends and for ten years following the end of the calendar year in which the agreement is terminated or for ten years following the year any vaccine recipient was immunized during the final year of the agreement. If a notice of a claim or lawsuit has been made, this agreement(s) should be retained until after final disposition of the claim or litigation (including appeals).

**SUPPORTING DOCUMENTS:**

Supporting documents, additional forms, and Branch policies may be obtained at http://www.immunize.nc.gov/ or by calling 1-877-873-6247.