Reset Form

IMMUNIZATION PROVIDER DISENROLLMENT

State Form 54840 (R / 8-25)
INDIANA DEPARTMENT OF HEALTH, IMMUNIZATION DIVISION

INSTRUCTIONS: *1.This form must be completed for individual public and private facilities who are no longer participating in as a publicly funded vaccine provider. By completing this form, you will no longer be able to received publicly funded vaccine for eligible children.*
2. Email this completed form to immunize@health.in.gov

A. Provider Information

Facility Name _____ Provider PIN Number _____

Medical Officer Name _____ (MD DO NP) Physician License Number _____

Contact Name _____ Email Address _____

B. Reason for Disenrollment

- ☐ Facility Closed
- ☐ Provider/Facility Merged with another location
  VFC PIN #_____
- ☐ Provider no longer enrolled in Medicaid
- ☐ Provider no longer seeing children (adult only site)
- ☐ Provider no longer offers immunizations
- ☐ No longer wishes to offer publicly funded vaccine
  - ☐ Does not see enough patients
  - ☐ Dissatisfaction with program
  - ☐ Feels program requirements are too burdensome
  - ☐ Other reason
    Please explain: _____
- ☐ Provider Inactivity – no orders in last 12 months
- ☐ Program Noncompliance
  - ☐ Storage Unit/Temperature Issues
  - ☐ Eligibility/Screening
  - ☐ Non compliance with Recertification
  - ☐ Registry/EMR Issues
  - ☐ Other _____
- ☐ Medical Officer Changed (Departed/Deceased)
  - ☐ New officer will be enrolling
  - ☐ New officer will not be enrolling
- ☐ Provider only enrolled for temporary outbreak
- ☐ Other reason not listed
  Please explain:_____

Signature _____ Date *(month, day, and year)* _____
(Medical Officer listed in Section A.)

For Office Use Only

Date Form Received *(month, day, year)* _____

Date Entered into VTrckS and VOMS *(month, day, year)* _____ Entered by _____

Actions Taken *(Check all that apply.)*

☐ PIN Inactivated ☐ Field Representative Notified to transfer vaccine