

# PROVIDER WITHDRAWAL FORM

\*PIN: \_\_\_\_\_ \*Withdrawal Date: \_\_\_\_\_

Please complete this form when you no longer wish to participate in the Texas Vaccine for Children (TVFC) Program. Fax the completed form to your Regional TVFC contact. Any remaining state vaccine will be picked up within 5 days of withdrawal from the TVFC Program. Please remember that Texas Health Steps providers may not refer Texas Health Steps patients elsewhere for immunizations.

Name of Facility: \_\_\_\_\_

Provider Name: \_\_\_\_\_  
(Last Name) (First Name) (MI) (Title)

Contact Name: \_\_\_\_\_  
(Last Name) (First Name) (MI) (Title)

Address: \_\_\_\_\_  
(Street Address) (City) (Zip) (County)

Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## \*Reason for Withdrawal:

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Facility is Closing            | <input type="checkbox"/> 7. No Longer Enrolled in Medicaid        |
| <input type="checkbox"/> 2. No Longer Seeing Children      | <input type="checkbox"/> 8. Relocating Out of Area<br>*New County |
| <input type="checkbox"/> 3. Too Much Paperwork             | _____   |
| <input type="checkbox"/> 4. Staffing Issues                | <b>New Address</b>  |
| <input type="checkbox"/> 5. Physician no longer practicing | _____   |
| <input type="checkbox"/> 6. Not Using TVFC Vaccine         | <input type="checkbox"/> 9. Other:                                |
|  | _____   |
|  | _____   |
|  | <input type="checkbox"/> 10. Provider Withdrawn by HSR/AO         |

## \*Required Fields

### For HSR/LHD Use Only:

Date faxed to HSR: \_\_\_/\_\_\_/\_\_\_

Date faxed to AO: \_\_\_/\_\_\_/\_\_\_

Date vaccines picked up: \_\_\_/\_\_\_/\_\_\_