Select purpose of form below:

☐ **Initial Enrollment**

☐ **Revalidation**
NPI #_____
MCD #_____

☐ **Update**
NPI #_____
MCD #_____

EPSDT AGREEMENT

I, the undersigned participating physician/provider, agree to carry out the key components of a thorough medical well-child examination. The examination/screen must, at a minimum, include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development),
- a comprehensive **unclothed** physical exam,
- appropriate immunizations according to age and health history,
- laboratory tests (including blood lead level assessment appropriate for age and risk factors),
- health education (including anticipatory guidance), and
- treatment and/or referral, if indicated.

In addition, I understand that the performance of these services must be documented, as all medical records pertaining to the EPSDT Program are subject to audit by federal and state agency representatives. Also, I agree to follow up on all referred cases and to document whether or not the initial referral visit was kept by the recipient.

_____
Provider's Printed Name

_____
Physical Street Address

_____
City, State and Zip Code+4

_____
Telephone Number

_____
Provider NPI Number

_____
CLIA Number

_____
Provider's Signature
(Original signature of the enrollee is required.)

Do you wish to be listed in the EPSDT published list? ☐ Yes ☐ No

The Alabama Medicaid Agency does not enroll providers in the VFC Program. To enroll in the VFC Program, contact the Alabama Department of Public Health, Immunization Division at (800) 469-4599.