EXPRESS SCRIPTS CANADA MODIFICATION TO DENTAL PROVIDER FORM

This form is not applicable to the NIHB program.

It is the responsibility of the provider to notify Express Scripts Canada in writing of any changes to their provider information. Please allow ten (10) business days for Express Scripts Canada to process your request.

PROVIDER INFORMATION (Mandatory Information)

Language Preference: ❑ **English** ❑ **French**

Provider Number: ______________________

Licence Number: ______________________

Specialty: ______________________

First Name: ______________________ **Last Name:** ______________________

TYPE OF REQUEST:

❑ Provider Update ❑ Additional Office(s)

❑ Specialty Change ❑ Switch to Incorporation (*new Provider #*): ______________

❑ Other (*please specify*): ______________________

❑ Additional Office or ❑ Update Office

Office ID (CDAnet/ACDQ/DACnet™/CDHA-ACHDnet™): ______________

Effective Date: ______________

Clinic Name: ______________

Street Address: ______________

Suite / PO Box: ______________

City/Prov./Postal code: ______________

Phone No.: ______________ Fax No.: ______________

Email Address: ______________

I wish to receive payment by: ❑ cheque or ❑ direct deposit

Bank Name: ______________

Branch Name: ______________

Branch Address: ______________

City/Prov./Postal code:

Bank No.: | | | | Branch/ Transit No.: | | | | | |

Account No.: | | | | | | | | | | | |

ATTACH: ❑ VOID Cheque or ❑ Official Bank Letter

❑ Additional Office or ❑ Update Office

Office ID (CDAnet/ACDQ/DACnet™/CDHA-ACHDnet™): ______________

Effective Date: ______________

Clinic Name: ______________

Street Address: ______________

Suite / PO Box: ______________

City/Prov./Postal code: ______________

Phone No.: ______________ Fax No.: ______________

Email Address: ______________

I wish to receive payment by: ❑ cheque or ❑ direct deposit

Bank Name: ______________

Branch Name: ______________

Branch Address: ______________

City/Prov./Postal code:

Bank No.: | | | | Branch/ Transit No.: | | | | | |

Account No.: | | | | | | | | | | | |

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Office ID (CDAnet/ACDQ/DACnet™/CDHA-ACHDnet™): ______________

Effective Date: ______________

Clinic Name: ______________

Street Address: ______________

Suite / PO Box: ______________

City/Prov./Postal code: ______________

Phone No.: ______________ Fax No.: ______________

Email Address: ______________

I wish to receive payment by: ❑ cheque or ❑ direct deposit

Bank Name: ______________

Branch Name: ______________

Branch Address: ______________

City/Prov./Postal code:

Bank No.: | | | | Branch/ Transit No.: | | | | | |

Account No.: | | | | | | | | | | | |

ATTACH: ❑ VOID Cheque or ❑ Official Bank Letter

❑ I instruct Express Scripts Canada to set up or change my direct deposit payments. This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account. All information will be treated as private and confidential. I will advise Express Scripts Canada promptly of any changes to bank, branch or account number.

______________________ ______________________ ______________

Provider Name (please print full name) **Provider Signature** (NO STAMPS) **Date**

Return the completed, signed form with VOID cheque (photocopy of VOID cheque is acceptable) or Official Bank Letter (if applicable) by fax or mail to:
Express Scripts Canada, Attn: Provider Relations, 5770 Hurontario St., 10th Floor, Mississauga, ON L5R 3G5, Fax Number: 1 855 622-0669

(if necessary, sign and attach another form for more offices)