EXPRESS SCRIPTS®

MODIFICATION TO DENTAL PROVIDER INFORMATION FORM

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 to Complete)

Provider Number: _____

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

Surname: _____

First Name: _____

Clinic Name: _____

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

❑ SECTION A – COMMUNICATIONS (Change)

General Communication *(select one)*:

❑ **E-mail Address** _____

❑ **Fax** _____ ❑ **Mail**

❑SECTION B – CONTACT INFORMATION (Change)

OLD ADDRESS	NEW ADDRESS
Effective Date: _____	
Clinic Name:_____	Clinic Name: _____
Street Address: _____	Street Address: _____
Suite/ P.O. Box: _____	Suite/ P.O. Box: _____
City/ Prov/ Postal Code: _____	City/ Prov/ Postal Code: _____
Phone No.: _____ Fax No.: _____	Phone No.: _____ Fax No.: _____
E-mail Address: _____	E-mail Address: _____

❑ SECTION C – ADDITIONAL OFFICES (Change or Set Up) (if required, use a separate page and attach)

ADDITIONAL OFFICE #1	ADDITIONAL OFFICE #2
Effective Date: _____	Effective Date: _____
Status *(select one)*: ❑ Owner ❑ Associate	Status *(select one)*: ❑ Owner ❑ Associate
Office ID(CDAnet/ ACDQ/ DACnet™/ CDHA-ACHDnet™): _____	Office ID (CDAnet/ ACDQ/ DACnet™/ CDHA-ACHDnet™): _____
Clinic Name:_____	Clinic Name: _____
Street Address: _____	Street Address: _____
Suite/ P.O. Box: _____	Suite/ P.O. Box: _____
City/ Prov/ Postal Code: _____	City/ Prov/ Postal Code: _____
Phone No.: _____ Fax No.: _____	Phone No.: _____ Fax No.: _____
E-mail Address: _____	E-mail Address: _____

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❑ SECTION D – PAYMENT INFORMATION (Change or Set Up for Electronic Funds Transfer/ Statements)

I instruct Express Scripts Canada to set up or change my direct EFT 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.

Effective Date: _____ ❑**NEW** or ❑**REPLACE** Banking Information

Office ID (CDAnet/ ACDQ/ DACnet™/ CDHA-ACHDnet™): _____**ATTACH:** ❑VOID Cheque or ❑Official Bank Letter

Dental Office Phone No.: _____

Bank Name:_____ Branch Name: _____

Branch Address:_____

City: _____ Province: _____ Postal Code:_____

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

❑ I choose to receive payment by cheque ❑ I choose to receive paper payment statements

❑ SECTION E – OTHER (Change to Incorporation, Specialty, or Other)

Effective Date:_____ ❑ Incorporation*(include new unique Provider Number)*:_____

❑ Specialty:_____ ❑ Other (Description of Change): _____

❑ SECTION F – Exemption for payment via direct deposit and electronic payment statements

You may be exempt from electronic bundling if you work in a remote area and are unable to reliably connect to the internet or you are planning to close your practice within a one year period and cannot feasibly incorporate this change.

If either circumstance is applicable and you would like to be considered for exemption, please provide the details in the space below:

_____

_____

_____ _____ _____

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

Return the completed, signed form with VOID cheque or Official Bank Letter (if applicable) by fax or mail to (photocopy of VOID cheque is acceptable when faxing):

Express Scripts Canada, Attention: Provider Relations, 5770 Hurontario St., 10th Floor, Mississauga, ON L5R 3G5, Fax Number: 1-855-622-0669.