

EXHIBIT B – Provider Registration Declaration

ESC Provider Number(s):
Effective Date:
<p>Type of Request, please check all of those that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> New opening <input type="checkbox"/> Change in ownership/directors and/or officers <ul style="list-style-type: none"> <input type="checkbox"/> Change in legal business name <input type="checkbox"/> Change in owners, directors and/or officers, i.e., adding or removing <input type="checkbox"/> Amalgamation of companies <input type="checkbox"/> Set up Electronic Funds Transfer (EFT) or change to EFT (electronic funds transfer)/ direct deposit/ bank account information <input type="checkbox"/> Change in pharmacy operating address <input type="checkbox"/> Change in pharmacy banner/chain operating name <input type="checkbox"/> Change in pharmacy dispensing fee <input type="checkbox"/> Other: specify: _____
<p>Documents that must be submitted:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Governance documents that list the names of all owners of the company, partnership or entity <input type="checkbox"/> Copies of government issued ID's for all owners of the pharmacy and the pharmacy manager <input type="checkbox"/> Certificate of liability insurance (if the request is for a new opening or change in ownership) <input type="checkbox"/> Void cheque with legal business name clearly stated on the cheque <input type="checkbox"/> Proof of pharmacy accreditation from provincial pharmacy regulatory body <input type="checkbox"/> All pages of Exhibit B (write N/A on blank pages) <input type="checkbox"/> A list of all additional fully or partially owned pharmacies by any owner. This can be added on the Exhibit B itself or provided on a separate sheet if there are multiple pharmacies to list. The list must include the ESC provider number, operating name, complete pharmacy operating address.

SECTION A: Provider Legal Business Information

Type of Business <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership	Legal Business Name <i>(must match Provider's governance documents (Articles of Inc., Partnership Agreement, etc.), a copy of which you are required to submit with this Agreement. Failure to provide all applicable documents may cause delays of this application and/or its denial.)</i>		
Legal Business Registered Office Address			
City	Province	Postal Code	
Telephone	Fax	Email	

Owners, Officers and Directors of the Company (attach a separate sheet if necessary):

Please list all ESC Provider numbers where an owner, officer or director has ownership in any additional pharmacies. If more than six owners, officers and/or directors, please print and attach additional copies of this page. *If applicable

1 Name (first and last)		Occupation	
Pharmacy College Registration (License) Number*		Government Photo ID No. e.g., Driver's License or Passport No. (attach copy of ID)	
Additional Pharmacy(ies) Owned		ESC Provider Number(s)*	Pharmacy Operating Name
Pharmacy Address			
City		Province	Postal Code
2 Name (first and last)		Occupation	
Pharmacy College Registration (License) Number*		Government Photo ID No. e.g., Driver's License or Passport No. (attach copy of ID)	
Additional Pharmacy(ies) Owned		ESC Provider Number(s)*	Pharmacy Operating Name
Pharmacy Address			
City		Province	Postal Code

Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

3 Name (<i>first and last</i>)		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. (<i>attach copy of ID</i>)		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code
4 Name (<i>first and last</i>)		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. (<i>attach copy of ID</i>)		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code
5 Name (<i>first and last</i>)		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. (<i>attach copy of ID</i>)		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

6 Name (<i>first and last</i>)		Occupation	
Pharmacy College Registration (License) Number*		Government Photo ID No. e.g., Driver's License or Passport No. (<i>attach copy of ID</i>)	
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

<p>Have any of the Owners, Officers, Directors or Pharmacists listed above ever applied and been denied an ESC or Eclipse Provider Number?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes →Name(s):</p>
<p>Details</p>
<p>Have any of the Owners, Officers, Directors or Pharmacists listed above had an ESC or Eclipse Provider Number and lost billing privileges?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes →Name(s):</p>
<p>Details</p>
<p>Do any of the Owners, Officers, Directors or Pharmacists listed above have any pending concerns at their respective regulatory body(ies)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes →Name(s):</p>
<p>Details</p>

SECTION B: Pharmacy Information

(If registering more than one pharmacy under the same provider legal business name, make additional copies of section B)

Language <input type="checkbox"/> English <input type="checkbox"/> French		ESC Provider Number	Pharmacy License/ Accreditation Number
Pharmacy Operating Name		Banner/ Chain Name	
Pharmacy Address			
City		Province	Postal Code
Pharmacy Telephone	Pharmacy Fax	Pharmacy Email	
Pharmacy Commercial General Liability Insurance <i>(include certificate for general commercial liability insurance, including minimum coverage amount. See Section 4.A. of the Agreement)</i>	Usual and Customary Professional Fee \$	Ontario ONLY: Ontario Drug Benefit (ODB) Dispensing Fee \$	
Pharmacy Manager Name <i>(first and last)</i>			
Pharmacy Manager's Registration License Number *		Government Photo ID No. e.g., Driver's License or Passport No. <i>(attach copy of ID)</i>	

If purchasing an existing business, please indicate the following:

Existing Legal Business Name			
Existing Operating Name			
Existing Address			
City		Province	Postal Code
Existing Telephone	Existing Fax	Existing Email	
Existing Provider Number			

Payment Information – Electronic Funds Transfer (EFT):

I instruct ESC to set up or update my direct EFT payments. This form authorizes deposits to the bank account and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. I will advise ESC promptly of any changes to the bank, branch or account number. I understand, EFT is the only payment option available for claims reimbursement.

Banking Information Attach: <input type="checkbox"/> VOID Cheque OR <input type="checkbox"/> Official Bank Letter <i>A copy of a pre-printed VOID cheque or Official Bank Letter is required. Corporate details must be included on either the VOID Cheque or Official Bank Letter. If the attached cheque is not pre-printed with the pharmacy's legal and/or operating name, please provide a letter signed by an officer of your bank, indicating the account number and certifying you as the account holder.</i>		
Account Holder Name		
Bank Name	Branch Name (if applicable)	
Branch Address		
City	Province	Postal Code*
Institution No. / Bank Code	Branch/ Transit No.	Account No.

Pharmacy Software Vendor Information (EDI Claims Submission):

Name of Vendor

Acknowledgment and Agreement

By signing this declaration, I am aware that the information provided may be validated and audited by ESC at any time, and that any change in the original declaration requires a re-application by the provider. Providers shall notify ESC in writing of any change or adjustment to information above in compliance with section 4 of the Pharmacy Provider Manual.

ESC Service Fees:

I have read and understand that ESC charges Service Fees for ESC Services as outlined in section 2.6 of the Pharmacy Provider Manual. All supporting documents and pages of this form must be returned by:

Fax at: 1 855 622-0669 or
 Mail to: Express Scripts Canada
 Attention: Provider Relations
 5770 Hurontario Street, 10th Floor
 Mississauga, ON L5R 3G5

Completed by:

Signature, Owner or Director of Business (no stamps)	Printed Full Name of the Owner or Director of Business
Contact Telephone Number of the Owner or Director	Date Signed (mm/dd/yyyy)