DENTURIST PROVIDER ENROLMENT FORM

Return the completed, signed form with VOID cheque (photocopy of VOID cheque is acceptable) or Official Bank Letter by:
Uploading to: Provider Contact Form under the section Healthcare Providers – Become a Healthcare Provider
https://www.express-scripts.ca/healthcare-providers/become-a-provider
Fax to: 1 855 622-0669
Mail to: Express Scripts Canada, Attention: Provider Relations
6985 Financial Drive, Suite 300
Mississauga, ON L5N 0G3
(If necessary, complete another form for additional offices)

Provider Information:

Office/Clinic ID (DACnet™): _____

Provider Number: _____

***License No.:** _____

Effective Date: _____

Office/Clinic Name: _____

Surname: _____ **First Name:** _____

Street Address: _____

Suite / PO Box: _____

City / Prov. / Postal Code: _____

Phone No.: _____ **Fax No.:** _____

Email Address: _____

Language ◯ **English** ◯ **French**

***Assigned by the appropriate Provincial / Territory Licensing Body. By signing the Enrolment Form, Providers attest to their registration and good standing with their respective Dental Provider Provincial / Territory Licensing Body.**

Payment Information – Electronic Funds Transfer (EFT):

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

Banking Information

Attach: ◯ VOID Cheque OR
◯ Official Bank Letter

A copy of a pre-printed VOID cheque or Official Bank Letter is required.

Account Holder Name

Institution No./ Bank Code	*Branch/ Transit No.*

Account No.

After you complete, sign and return this Denturist Provider Enrolment Form, Express Scripts Canada will review the information contained herein and once approved, Express Scripts Canada will authorize the applicant (you) as a Provider (the "Provider") allowing you to submit claims directly to Express Scripts Canada for payment of eligible services provided to Members who are eligible for dental benefits under certain dental benefit plans.

Provider's submission of claims to Express Scripts Canada will be subject to the Terms and Conditions of this Denturist Provider Enrolment Form and the Denturist and Dental Hygienist Provider Manual (the "Manual"). Please note the Manual is updated from time to time as necessary and at Express Scripts Canada's sole discretion.

As signatory to this form, you will be responsible for all services billed by Provider, and paid for by Express Scripts Canada, regardless of the corporate structure of the clinic from which you operate. A submission of a claim under your unique Provider Number indicates your understanding and acceptance of Express Scripts Canada's Terms and Conditions. Provider attests to their enrolment and good standing with their respective Dental Provider Provincial / Territory Licensing Body.

As set forth in the Manual, Terms and Conditions include, but are not limited to:

- Provider licensure and eligibility requirements
- Member eligibility requirements
- Coordination with other health plans
- Documentation submission process and requirements
- Benefits and applicable limitations
- Requirements for Providers on the use of treatment codes and standard definitions
- Administrative Provider Audit Program which includes an on-site Audit Program
- Maintenance of relevant documentation and records

Express Scripts Canada may terminate this agreement upon sending the Provider a written notification of termination of Provider's enrolment hereunder, which termination will be effective on the date indicated in the termination notice.

Provider Name (*please print full name*)	**Provider's Original Signature (*no stamps*)**	**Date Signed *(yyyy-mm-dd)***