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EXPRESS SCRIPTS®

INDEPENDENT DENTAL HYGIENIST PROVIDER ENROLMENT FORM
NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM

Complete, sign and return ALL pages of the Enrolment Form by fax or mail to:
Fax No.: 1-855-622-0669
Mail: Express Scripts Canada, Attention: Provider Relations, 5770 Hurontario St., 10th Floor, Mississauga, ON L5R 3G5

FORM MUST BE COMPLETED BY ALL INDEPENDENT DENTAL HYGIENE PROVIDERS IN THE OFFICE

INDEPENDENT DENTAL HYGIENIST PROVIDER INFORMATION

License No.:	CDHAnet # (if applicable):
Surname:	First Name:
Language: ○ English ○ French	
Select your delivery mode preference for each type of communication:	**General Communication** (select one): ○ Email ○ Fax ○ Mail **Predetermination Letters** (select one): ○ Fax ○ Mail

Please indicate your status in the clinic *(select one)*:
- ○ Associate (not an owner and/or owner partner)
- ○ Owner and/or Owner Partner
- ○ Salary

CLINIC/OFFICE INFORMATION

If more space is required to include additional offices, please provide the information required below on an additional page and attach to the completed Enrolment form.

MAIN OFFICE	ADDITIONAL OFFICE
Effective Date (YYYY-MM-DD):_____	Effective Date (YYYY-MM-DD): _____
Status *(select one)*: ○ Owner ○ Associate ○ Salary	Status *(select one)*: ○ Owner ○ Associate ○ Salary
Clinic and/or Business Name:_____	Clinic and/or Business Name:_____
Street Address: _____	Street Address: _____
Suite/ P.O. Box: _____	Suite/ P.O. Box: _____
City_____	City_____
Prov._____ Postal Code: _____	Prov._____ Postal Code:_____
Phone No.: _____ Fax No.: _____	Phone No.: _____ Fax No.:_____
Email Address: _____	Email Address: _____

PAYMENT INFORMATION – ELECTRONIC FUNDS TRANSFER (EFT) AND REMITTANCE STATEMENTS

I instruct Express Scripts Canada to set up 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.

Complete bank information below and ○ Attach a VOID Cheque or Official Bank Letter
(Photocopy of VOID cheque is acceptable when faxing)

Remittance Statements (select one): ○ Online ○ Mail

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province: _____ Postal Code: _____

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

By completing and signing this Independent Dental Hygienist Provider Enrolment form you will become a Provider under the NIHB Program (the "Provider") and will be given a unique Provider Number. This unique Provider Number will allow you to submit claims directly to Express Scripts Canada for payment for services provided to NIHB Clients who are eligible for dental benefits under Health Canada's NIHB Program.

Upon the submission of a claim, you will be subject to the Terms and Conditions of the NIHB Program, the Express Scripts Canada NIHB Dental Claims Submission Kit (the "Kit"), the NIHB Dental Benefits Guide (the "Guide"), and the NIHB Fee Grid for Dental Hygienists (province/territory specific). These documents are located on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca. Please note the Kit and the Guide are updated regularly. It is your responsibility to comply with the *current* version of both the Kit and the Guide. Revisions are also noted in the NIHB Dental Newsletter which is also posted on the NIHB Claims Services Provider Website.

As signatory to this Enrolment form, you will be responsible for all services billed and paid by Express Scripts Canada to the unique Provider Number assigned to your application 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 these Terms and Conditions. In addition, Providers attest to their enrolment and good standing with their respective Dental Provider Province/Territory Licensing Body.

Terms and Conditions are, but not limited to:

- Provider licensure and provider eligibility requirements. Dental procedures must be ordered or performed by a qualified independent Dental Hygienist who is legally able to practice his/her profession in the province/territory of service;
- NIHB Client eligibility requirements;
- Co-ordination with other Client health plans;
- Claims documentation submission process and requirements;
- Copies of all radiographs must be provided as requested to other Dental professionals at no charge (if applicable);
- NIHB Benefits and applicable limitations. Submitted claims must only include procedures that are eligible for coverage under the NIHB program as defined for Dental Hygienists;
- Requirements for Dental Hygiene Providers on the use of treatment codes and standard definitions;
- The fees defined in the NIHB Dental Hygienist Fee Grid (province/territory specific) constitute payment in full for services provided. Clients must not be billed for any additional fees or asked for upfront payment for procedures covered by NIHB ;
- Full compliance with any requested audits of claims submissions by Health Canada or ESC's Administrative Provider Audit Program which may include an on-site audit component; and,
- Maintenance of relevant documentation and records to support your claims. The NIHB Program will seek re-payment for any claims paid that cannot be verified by documentation.

Services provided will only be eligible for payment if they comply with all NIHB Program policies and guidelines.

The term of this enrolment shall commence on the start date of the unique provider number issued by Express Scripts Canada. Express Scripts Canada will notify the provider if your provider number is terminated. Please refer to the Kit for further terms and conditions of enrolment.

Provider No.		**Date (YYYY-MM-DD)**
Contact Name	☐ SIGNED	**Independent Dental Hygienist Signature (no stamps)**
Prepared By		**Phone No.**