



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., 10<sup>th</sup> Floor, Mississauga, ON L5R 3G5

DENTAL PROVIDER INFORMATION	
Unique Provider No.: 012345678	Language: <input checked="" type="checkbox"/> English <input type="checkbox"/> French
Surname: DOE	First Name: JOHN
License No.: 23456	Specialty: GENERALIST
Select your delivery mode preference for each type of communication:	General Communication (select one): <input checked="" type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Mail Predetermination Letters (select one): <input checked="" type="checkbox"/> Fax <input type="checkbox"/> Mail
Please indicate your status in the clinic (select one): <input type="checkbox"/> Associate (not an owner and/or owner partner) <input checked="" type="checkbox"/> Owner and/or Owner Partner <input type="checkbox"/> Salary or <input type="checkbox"/> Per Diem Dental Professional Contracted by Health Canada Regional Offices	

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: JANUARY 1, 2013	Effective Date: _____
Status (select one): <input type="checkbox"/> Owner <input type="checkbox"/> Associate <input type="checkbox"/> Salary or <input type="checkbox"/> Per Diem Dental Professional Contracted by Health Canada Regional Offices	Status (select one): <input type="checkbox"/> Owner <input type="checkbox"/> Associate <input type="checkbox"/> Salary or <input type="checkbox"/> Per Diem Dental Professional Contracted by Health Canada Regional Offices
Office ID (CDAnet/ DACnet™/ ACDQ): 9876	Office ID (CDAnet/ DACnet™/ ACDQ): _____
Clinic Name: ABC DENTAL CLINIC	Clinic Name: *COMPLETE IF WORKING
Street Address: 123 ANY STREET	Street Address: AT MULTIPLE
Suite/ P O Box: 1001	Suite/ P O Box: LOCATIONS *
City: ANYTOWN	City: _____
Prov: ON Postal Code: A1A 1A1	Prov: _____ Postal Code: _____
Phone No: 123-555-4444 Fax No: 123-555-4445	Phone No: _____ Fax No: _____
E-mail Address: JOHNDOE@ABCDENTAL.CA	E-mail Address: _____

PAYMENT INFORMATION – ELECTRONIC FUNDS TRANSFER (EFT)	
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	
Office ID (CDAnet/ DACnet™/ ACDQ): 9876	
Complete bank information below and <input checked="" type="checkbox"/> Attach a VOID Cheque or Official Bank Letter (Photocopy of VOID cheque is acceptable when faxing)	
Bank Name: FIRST BANK	Branch Name: CITY CENTRE
Branch Address: 456 MAIN STREET	
City: ANYTOWN	Province: ON Postal Code: A1A 1A1
Bank No.: 0000 Branch/ Transit No.: 999999 Account No.: 011234567	

By completing and signing this Dental Provider Enrolment form you will become a Provider under the NIHB Program (as defined herein) (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 Clients who are eligible for dental benefits under Health Canada's NIHB Program.

Upon the submission of a claim as a Provider, you will be subject to the Terms and Conditions of the NIHB Program, the Express Scripts Canada NIHB Dental Claims Submission Kit (the "Kit"), and the NIHB Dental Benefits Guide (the "Guide"). Both documents are located on the NIHB Claims Services Provider Website at [www.provider.express-scripts.ca](http://www.provider.express-scripts.ca). Please note the Kit and the Guide are updated regularly. It is the Provider's responsibility to be in possession of 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 eligibility requirements;
- Client eligibility requirements;
- Coordination with other health plans;
- Documentation submission process and requirements;
- Benefits and applicable limitations;
- Requirements for Dental Providers on the use of treatment codes and standard definitions;
- Administrative provider audit program which includes an on-site audit program; and,
- Maintenance of relevant documentation and records to support your claims.

The term of this enrolment shall commence on the effective date (start date) of the unique Provider Number issued by Express Scripts Canada. Express Scripts Canada may serve the Provider a written notification of termination of Providers' enrolment hereunder. Please refer to the Kit for further details.

012345678

Provider No.

JANE DOE

Contact Name

JohnDoe

Dental Provider's Original Signature (NO STAMPS)

JANE DOE

Prepared By

123-555-4444

Phone No.