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EXPRESS SCRIPTS®

Non-Insured Health Benefits (NIHB) Program
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.

PROVIDER INFORMATION (*Mandatory to Complete)

*Provider Number: _____ *Language Preference: ○ English ○ French

*Surname: _____ *First Name: _____

*Clinic Name: _____ *Office ID (CDAnet/DACnet/Réseau ACDQ/CDHAnet): _____

SECTION A – COMMUNICATIONS (Change)

General Communication *(select one)*: ○ Email _____ ○ Fax _____ ○ Mail

Predetermination Letters *(select one)*: ○ Fax _____ ○ Mail

SECTION B – CONTACT INFORMATION (Change)

OLD ADDRESS	NEW ADDRESS
Effective Date (yyyy-mm-dd) : _____	
Clinic Name: _____	Clinic Name: _____
Street Address: _____	Street Address: _____
P.O. Box: _____ City: _____	P.O. Box: _____ City: _____
Prov: _____ Postal Code: _____	Prov: _____ Postal Code: _____
Phone No.: _____ Fax No.: _____	Phone No.: _____ Fax No.: _____
Email Address: _____	Email 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 ○ Salary/ Per Diem Dental Professional Contracted by Health Canada Regional Offices	Status *(select one)*: ○ Owner ○ Associate ○ Salary/ Per Diem Dental Professional Contracted by Health Canada Regional Offices
Office ID (CDAnet/ DACnet/Réseau ACDQ/CDHAnet): _____	Office ID (CDAnet/ DACnet/Réseau ACDQ/CDHAnet): _____
Clinic Name: _____	Clinic Name: _____
Street Address: _____	Street Address: _____
P.O. Box: _____ City: _____	P.O. Box: _____ City: _____
Prov: _____ Postal Code: _____	Prov: _____ Postal Code: _____
Phone No.: _____ Fax No.: _____	Phone No.: _____ Fax No.: _____
Email Address: _____	Email Address: _____

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

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/DACnet/Réseau ACDQ/CDHAnet): _____ **Attach:** ○ VOID Cheque **or** ○ Official Bank Letter

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province: _____ Postal Code: _____

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

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

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

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

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.