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EXPRESS SCRIPTS®

DENTAL 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

DENTAL PROVIDER INFORMATION

Unique Provider No.:	Language: ○ English ○ French
Surname:	First Name:
License No.:	Specialty:
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 **or** ○ Per Diem Dental Professional Contracted by FNIHB 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

Effective Date (YYYY-MM-DD):_____

Status *(select one)*: ○ Owner ○ Associate ○ Salary **or** ○ Per Diem Dental Professional Contracted by FNIHB Regional Offices

Office ID (CDAnet/ DACnet™/ ACDQ): _____

Clinic Name: _____

Street Address: _____

Suite/ P.O. Box: _____

City: _____

Prov.: _____ Postal Code: _____

Phone No.: _____ Fax No.: _____

Email Address: _____

ADDITIONAL OFFICE

Effective Date (YYYY-MM-DD):_____

Status *(select one)*: ○ Owner ○ Associate ○ Salary **or** ○ Per Diem Dental Professional Contracted by FNIHB Regional Offices

Office ID (CDAnet/ DACnet™/ ACDQ): _____

Clinic Name: _____

Street Address: _____

Suite/ P.O. Box: _____

City: _____

Prov.: _____ Postal Code: _____

Phone No.: _____ Fax No.: _____

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.

Office ID (CDAnet/ DACnet™/ ACDQ): _____ **Remittance Statements** (select one): ○ Online ○ Mail

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

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province: _____ Postal Code: _____

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

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 Indigenous Service 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 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.

_____

Provider No.

_____ _____

Contact Name **Dental Provider's Original Signature *(NO STAMPS)***

_____ _____

Prepared By **Phone No.**