

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 FNIHB Regional Offices	Status (select one): Owner Associate Salary/ Per Diem Dental Professional Contracted by FNIHB 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.