

ESI CANADA DENTAL PROVIDER ENROLMENT FORM
THE NON-INSURED HEALTH BENEFITS PROGRAM
 (NIHB Program)

DENTAL PROVIDER INFORMATION

Do you currently hold or have you previously held a Provider Number with the NIHB Program? ' Yes ' No

If yes, please indicate the provider number(s): _____, _____, _____

First Name: _____ Surname: _____

Please indicate your status in the clinic:

- ' Associate (*Not an owner and/or owner partner*)
- ' Owner and/or Owner Partner
- ' Salary/Per Diem Dental Professional (*circle one*)

INFORMATION REQUIRED UNDER EACH TYPE OF CHANGE (CHECK AND COMPLETE THE APPLICABLE BOX OF CHANGE)

ENROLMENT INFORMATION (Complete all information)

License Number (Assigned by the appropriate Province/Territory Licensing Body. By signing the enrolment form, Providers attest to their registration and good standing with their respective Dental Provider Province/Territory Licensing Body):

CDAnet Provider Number (if applicable): _____ CDAnet Office ID: _____

Réseau ACDQ Identification Number (if applicable): _____ Réseau ACDQ Office ID: _____

DACnet Provider Number (if applicable): _____ DACnet Office ID: _____

Software Vendor Name: _____ Software Version: _____

Specialty: _____ Language Preference
 English Français

Clinic Name (if any): _____

Street Address: _____ PO Box: _____ Suite: _____

City: _____ Prov/Terr: Postal Code

(Area Code) Telephone Number (Area Code) Fax Number
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Communication Mode Preferred: Email Mail Fax Email address: _____

CHANGE OF ADDRESS

End Date of Old Address: _____

Start Date of New Address: _____

OLD ADDRESS**NEW ADDRESS**

Clinic Name (if any): _____

Street Address: _____

Suite/PO Box: _____

City: _____
Prov/Terr: Postal Code
□□ □□□□□□□□City: _____
Prov/Terr: Postal Code
□□ □□□□□□□□

(Area Code) Telephone Number

(Area Code) Telephone Number

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(Area Code) Fax Number

(Area Code) Fax Number

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Email Address: _____

ADDITIONAL OFFICE(S)

CDAnet Office ID: _____ (if applicable)

CDAnet Office ID: _____ (if applicable)

Réseau ACDQ Office ID: _____ (if applicable)

Réseau ACDQ Office ID: _____ (if applicable)

DACnet Office ID: _____ (if applicable)

DACnet Office ID: _____ (if applicable)

ADDITIONAL OFFICE # 1**ADDITIONAL OFFICE # 2**

Clinic Name (if any): _____

Street Address: _____

Suite/PO Box: _____

City: _____
Prov/Terr: Postal Code
□□ □□□□□□□□City: _____
Prov/Terr: Postal Code
□□ □□□□□□□□

(Area Code) Telephone Number

(Area Code) Telephone Number

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If you have more than two additional offices please provide the information required above on an additional page and attach to the completed enrolment form.

OTHER (CHANGE IN SPECIALTY, INCORPORATION, CORRECTIONS, ETC.)

Effective Date of Change: _____

Description of Change: _____

ELECTRONIC FUNDS TRANSFER (EFT) PAYMENT INFORMATION

Complete this section to identify the account to which ESI Canada will direct EFT PAYMENTS and **attach a void cheque**. (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**). **You must advise ESI Canada promptly of any changes to bank, branch or account number.**

Bank Name _____ Branch Name _____

Branch Address _____

City _____ Prov./Terr. Postal Code

Bank
Branch
Account Number

- -

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 provider number. This provider number will allow you to submit claims directly to ESI 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 Dental Claims Submission Kit (the "Kit") and the Provider Guide for Dental Benefits (the "Guide"). A copy of both documents will be provided upon enrolment and can also be found electronically at www.provider.esicanada.ca. Please note the Kit and the Guide are both periodically updated. It is the Provider's responsibility to be in possession of the current version of both the Kit and the Guide. Revisions are posted on the website.

As signatory to this form, you will be responsible for all services billed and paid by ESI Canada to the 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 Provider number indicates your understanding and acceptance of these Terms and Conditions.

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.

The term of this enrolment shall commence on the date the Provider receives a provider number from ESI Canada. ESI Canada may serve the Provider a written notification of termination of Providers' enrolment hereunder. Please refer to the Kit for further details.

Contact Name: _____

Dental Provider's Original Signature: _____

Prepared by: _____

Phone: (Area Code) Telephone Number
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