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/ ACDQ/ DACnet™):______________________

❑ SECTION A – COMMUNICATIONS (Change)

General Communication *(select one)*: ❑ E-mail ______________________ ❑ Fax ______________________ ❑ Mail

Predetermination Letters *(select one)*: ❑ Fax ______________________ ❑ Mail

❑ SECTION B – CONTACT INFORMATION (Change)

OLD ADDRESS	NEW ADDRESS
Effective Date: ______________________	
Clinic Name: ______________________	Clinic Name: ______________________
Street Address: ______________________	Street Address: ______________________
Suite/ P.O. Box: ______________________	Suite/ P.O. Box: ______________________
City/ Prov/ Postal Code: ______________________	City/ Prov/ Postal Code: ______________________
Phone No.: ____________ Fax No.: ____________	Phone No.: ____________ Fax No.: ____________
E-mail Address: ______________________	E-mail 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 FNIH Regional Offices	Status *(select one)*: ❑ Owner ❑ Associate ❑ Salary/ Per Diem Dental Professional Contracted by FNIH Regional Offices
Office ID (CDAnet/ ACDQ/ DACnet™): ______________________	Office ID (CDAnet/ ACDQ/ DACnet™: ______________________
Clinic Name: ______________________	Clinic Name: ______________________
Street Address: ______________________	Street Address: ______________________
Suite/ P.O. Box: ______________________	Suite/ P.O. Box: ______________________
City/ Prov/ Postal Code: ______________________	City/ Prov/ Postal Code: ______________________
Phone No.: ____________ Fax No.: ____________	Phone No.: ____________ Fax No.: ____________
E-mail Address: ______________________	E-mail 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/ ACDQ/ DACnet™): ______________________ ❑ 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: 905-712-0669.