

It is the responsibility of the provider to notify Express Scripts Canada in writing of any changes to their provider information. Please allow ten (10) business days for Express Scripts Canada to process your request.

Return the completed, signed form with VOID cheque (photocopy of VOID cheque is acceptable) or Official Bank Letter by:

Uploading to: Provider Contact Form under the section Healthcare Providers – Become a Healthcare Provider

<https://www.express-scripts.ca/healthcare-providers/become-a-provider>

Fax to: 1 855 622-0669

Mail to: Express Scripts Canada, Attention: Provider Relations

6985 Financial Drive, Suite 300

Mississauga, ON L5N 0G3

(If necessary, complete another form for additional offices)

* Represents mandatory fields

Provider Information:	Type of Modification:				
Provider Number: _____ License Number: _____ Specialty: _____ *First Name: _____ *Surname: _____	☐ Provider Office Update ☐ Additional Office(s) ☐ Specialty Change: _____ ☐ Other (please specify): _____				
☐ Additional Office or ☐ Provider Office Update	Payment Information – Electronic Funds Transfer (EFT): I instruct ESC to set up or update the Provider's direct EFT payments. This form authorizes deposits to the bank account indicated and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. The Provider will advise ESC promptly of any changes to the bank, branch or account number. The Provider understands that EFT is the only payment option available for claims reimbursement. Banking Information Attach: ☐ VOID Cheque OR ☐ Official Bank Letter <u>A copy of a pre-printed VOID cheque or Official Bank Letter is required.</u>				
*Office/Clinic ID (CDAnet/ACDQ/DACnet™/CDHA-ACHDnet™): _____ Street Address: _____ Suite / PO Box: _____ City/Prov./Postal code: _____ Phone No.: _____ Fax No.: _____ Email Address: _____ Language Preference: ☐ English ☐ French	<table border="1"> <tr> <td>Institution No./ Bank Code</td> <td>Branch/ Transit No.</td> </tr> <tr> <td colspan="2">Account No.</td> </tr> </table>	Institution No./ Bank Code	Branch/ Transit No.	Account No.	
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☐ Additional Office or ☐ Provider Office Update	Payment Information – Electronic Funds Transfer (EFT): I instruct ESC to set up or update the Provider's direct EFT payments. This form authorizes deposits to the bank account indicated and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. The Provider will advise ESC promptly of any changes to the bank, branch or account number. The Provider understands that EFT is the only payment option available for claims reimbursement. Banking Information Attach: ☐ VOID Cheque OR ☐ Official Bank Letter <u>A copy of a pre-printed VOID cheque or Official Bank Letter is required.</u>				
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Account No.					

*Provider Name (please print full name)

*Provider's Original Signature

*Date Signed (yyyy-mm-dd)