

DENTURIST PROVIDER ENROLMENT FORM

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)

Provider Information:	Payment Information – Electronic Funds Transfer (EFT):					
Office/Clinic ID (DACnet™): _____ Provider Number: _____ *License No.: _____ Surname: _____ First Name: _____ Street Address: _____ Suite / PO Box: _____ City / Prov. / Postal Code: _____ Phone No.: _____ Fax No.: _____ Email Address: _____ Language ☐ English ☐ French *Assigned by the appropriate Provincial / Territory Licensing Body. By signing the Enrolment Form, Providers attest to their registration and good standing with their respective Dental Provider Provincial / Territory Licensing Body.	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 A copy of a pre-printed VOID cheque or Official Bank Letter is required. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px; vertical-align: top;">Institution No./ Bank Code</td> <td style="width: 50%; padding: 5px; vertical-align: top;">Branch/ Transit No.</td> </tr> <tr> <td colspan="2" style="padding: 5px; vertical-align: top;">Account No.</td> </tr> </table>		Institution No./ Bank Code	Branch/ Transit No.	Account No.	
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After you complete, sign and return this Denturist Provider Enrolment Form, Express Scripts Canada will review the information contained herein and once approved, Express Scripts Canada will authorize the applicant (you) as a Provider (the "Provider") allowing you to submit claims directly to Express Scripts Canada for payment of eligible services provided to Members who are eligible for dental benefits under certain dental benefit plans.

Provider's submission of claims to Express Scripts Canada will be subject to the terms and conditions of this Denturist Provider Enrolment Form and those of the Denturist and Dental Hygienist Provider Manual (the "Manual") (collectively, "Express Scripts Canada's Terms and Conditions"). Please note the Manual is updated from time to time at Express Scripts Canada's sole discretion.

As signatory to this form, you will be responsible for all services billed by Provider, and paid for by Express Scripts Canada, 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 Express Scripts Canada's Terms and Conditions. Provider attests to their enrolment and good standing with their respective Dental Provider Provincial / Territory Licensing Body.

The Manual addresses various issues, including but not limited to:

- Provider licensure and eligibility requirements
- Requirements for Providers on the use of treatment codes and standard definitions
- Member eligibility requirements
- The Audit Program which includes a variety of verifications, including but not limited to: Member Verification, Next Day Audit Review, Desk Audit and On-site Audit.
- Coordination with other health plans
- Maintenance of relevant documentation and records
- Documentation submission process and requirements

Express Scripts Canada may terminate this agreement, with or without cause, upon sending the Provider a written notification of termination of Provider's enrolment hereunder, which termination will be effective on the date indicated in the termination notice.

Provider Name (please print full name)	Provider's Original Signature	Date Signed (yyyy-mm-dd)
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