EXPRESS SCRIPTS®

MODIFICATION TO PHARMACY/ MEDICAL SUPPLIES AND EQUIPMENT 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)

Apply all profile changes to: (check both if applicable):
- ❑ Express Scripts Canada Claims (Pharmacy Only)
- ❑ Non-Insured Health Benefits (NIHB) Program Claims (First Nations and Inuit) (Pharmacy and MS&E)

Provider No.: _____ Language Preference: ❑ English ❑ French

Operating Name: _____

Legal Name: _____

Current Address: _____

City/ Province/ Postal Code: _____

Phone No.: _____ Fax No.: _____

E-mail Address: _____

Contact Name: _____ Title: _____

❑ SECTION A – COMMUNICATIONS (Change)

Select your delivery mode preference for each type of communication:

General Communications (select one): ❑ E-mail ❑ Fax ❑ Mail

Prior Approval Letters (select one): ❑ Fax ❑ Mail

❑ SECTION B – OPERATING NAME (Change)

An Operating Name change is accepted when the **Legal Name and Ownership Names** remain the same.

Effective Date: _____

Current Operating Name: _____

New Operating Name: _____

❑ **Legal/ Ownership Name Change Required** (includes adding and/ or removing owner names)
If you check this box, an Express Scripts Canada representative will contact you directly to complete a NEW Agreement.

❑ SECTION C – ADDRESS (Change)

Effective Date: _____

Address: _____ Phone No.: _____

City: _____ Province: _____ Postal Code: _____

Preferred Communication Mode: Please select *one*:
❑ E-mail Address: _____ ❑ Fax No.: _____ ❑ Mail

❑ 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 Banking Information** ❑ **REPLACE Banking Information**

Complete bank information below and ❑ **Attach a VOID Cheque *or* Official Bank Letter** (Photocopy of VOID cheque is acceptable when faxing)

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province: _____ Postal Code: _____

Bank No.: | | | | Branch/ Transit No.: | | | | | Account No.: | | | | | | | | | | |

❑ SECTION E – DISPENSING FEE (Change) *(Non-Quebec Pharmacies ONLY)*

ONTARIO Pharmacies:	**All OTHER Pharmacies:**
Eff. Date: _____ Zone Set by ODB: _____	Eff. Date: _____
CURRENT U&C Fee: _____	CURRENT U&C Fee: _____
NEW U&C Fee: _____	NEW U&C Fee: _____

_____ _____
Full Name, Owner or Director of the Business (please print) Position/ Title

_____ _____
Signature Date

Return the completed, signed form (and VOID cheque or Official Bank Letter, if applicable) by fax or mail to:
ExpressScripts Canada, Attention: Provider Relations, 5770 Hurontario St., 10th Floor, Mississauga, ON L5R 3G5, Fax No.: 905-712-0669.