

## 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:**  Express Scripts Canada Claims (Pharmacy Only)  
(check both if applicable):  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: \_\_\_\_\_

<input type="checkbox"/> <b>SECTION A – COMMUNICATIONS (Change) (Delivery Mode)</b>	
<b>General Communications</b> (select one): <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Mail	<b>Prior Approval Letters</b> (select one): <input type="checkbox"/> Fax <input type="checkbox"/> Mail

<input type="checkbox"/> <b>SECTION B – OPERATING NAME (Change)</b>
An Operating Name change is accepted when the <b>Legal Name and Ownership Names</b> remain the same.
<b>Effective Date:</b> _____
<b>Current Operating Name:</b> _____
<b>New Operating Name:</b> _____
<input type="checkbox"/> <b>Legal/ Ownership Name Change Required</b> (includes adding and/ or removing owner names) <i>If you check this box, an Express Scripts Canada representative will contact you directly to complete a NEW Agreement.</i>

<input type="checkbox"/> <b>SECTION C – ADDRESS (Change)</b>
<b>Effective Date:</b> _____
Address: _____ Phone No.: _____
City: _____ Province: _____ Postal Code: _____
Preferred Communication Mode: Please select one: <input type="checkbox"/> E-mail Address: _____ <input type="checkbox"/> Fax No.: _____ <input type="checkbox"/> Mail

<input type="checkbox"/> <b>SECTION D – PAYMENT INFORMATION (Change or Set Up) (Electronic Funds Transfer)</b>
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.
<b>Effective Date:</b> _____ <input type="checkbox"/> <b>NEW Banking Information</b> <input type="checkbox"/> <b>REPLACE Banking Information</b>
Complete bank information below and <input type="checkbox"/> <b>Attach a VOID Cheque or Official Bank Letter</b> (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.:

<input type="checkbox"/> <b>SECTION E – DISPENSING FEE (Change) (Non-Quebec Pharmacies ONLY)</b>	
<b>ONTARIO Pharmacies:</b> Eff. Date: _____ Zone Set by ODB: _____ CURRENT U&C Fee: _____ NEW U&C Fee: _____	<b>All OTHER Pharmacies:</b> Eff. Date: _____ CURRENT 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:  
**Express Scripts Canada, Attention: Provider Relations, 5770 Hurontario St., 10<sup>th</sup> Floor, Mississauga, ON L5R 3G5, Fax No.: 1-855-622-0669.**