CHANGEOVER

NexgenRx Inc.

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Toronto, Ontario M9C 5L5

(Toronto Area) 647-722-3045 **(Toll Free) 1-866-394-3648** **(Toll Free Fax) 1-866-262-0007**
1-877-639-4369

PHARMACY PROVIDER AGREEMENT

In order for NexgenRx Inc. ("we" or "us") to properly identify and pay the pharmacy identified below ("you" or "your") for pharmaceutical and other claims submitted by you to us for adjudication and payment under pharmacy benefit plans administered by us on behalf of various pharmacy benefit plan sponsors and their respective eligible plan beneficiaries ("Cardholders"), it is necessary for you to provide us with the following information and agreement:

(PLEASE PRINT LEGIBLY, SIGN AND FAX COMPLETED AGREEMENT TO NEXGENRX AT THE ABOVE TOLL FREE FAX NUMBER; INCOMPLETE DOCUMENTATION OR MISSING ATTACHMENTS WILL DELAY THE PROVISION OF A PHARMACY PROVIDER NUMBER TO YOU)

(NOTE: IN THE CASE OF A SINGLE LEGAL ENTITY (INCLUDING A PHARMACY CHAIN) WHICH OWNS MORE THAN ONE PHARMACY, PLEASE ATTACH A SCHEDULE SETTING FORTH THE INFORMATION CALLED FOR IN PARAGRAPHS 1, 2 AND 3 BELOW FOR EACH SUCH PHARMACY)

1. Pharmacy Name, License and Affiliation

a) Legal Name

b) Operating (Trade) name, if different than legal name)

c) Pharmacy Licence / Accreditation Number
*assigned by Provincial Licensing Authority

d) Chain Affiliation, if any

e) If not affiliated with a chain, other pharmacies with which you are affiliated

2. Pharmacy Contact Data

a) Store Address

b) Mailing Address (if different)

c) Store Phone Number

d) Store Fax Number

e) Store e-mail address

f) Store Contact
Name:
Title:

g) Pharmacy Manager (as registered with Prov. Licensing Authority)
Name:
Cell Phone:

3. Usual and Customary Dispensing Fee (if any) $

(as registered with the relevant Provincial Licensing Authority)

4. Payment: Payment will be sent by us to you by Electronic Funds Transfer into your bank account (check desired box)

☐ on the next business day following the date of service for a charge of $0.10 for each claim paid by us

☐ bi-monthly on or about the 15th and 30th

Please attach a sample cheque, marked "void" in the space provided on the following page. This will enable us to make deposits to (but does not authorize us to make withdrawals from or any other transactions in respect of) your account.

5. Language Preferred / Langue Prēferēe (check desired box) ☐ English ☐ Français

6. Pharmacy Practice Management Software

Name of Software Utilized: |

We provide real-time pharmacy claims adjudication which is compatible with various pharmacy practice management software systems. Please contact your software vendor to confirm your ability to electronically send claims to us for adjudication and payment, and tell us above what practice management software you use.

You agree to notify us in writing, at our address noted above, should there be any changes in any of the information set forth in this Agreement. Upon our acceptance of this Agreement, we will sign where indicated below, assign you a Pharmacy Provider Number as shown below, and return a signed copy hereof to you. You agree to use your Pharmacy Provider Number in submitting any claims to us for adjudication and payment or in any other notice or communication with us. By your signature below, you

a) request that we issue you a Pharmacy Provider Number entitling you to submit claims to us in respect of pharmaceutical and other products and professional services provided by you to Cardholders;
b) agree to abide by the Pharmacy Provider Provisions, as the same may be amended from time to time in accordance with their terms (which are published on our website at www.nexgenrx.com, are hereby incorporated herein by reference in their entirety, and you acknowledge having read and understood), in providing any such products and/or services to any Cardholder; and
c) agree that the submission by you to us of any such claim for adjudication and payment shall
   (i) be subject to, and shall constitute confirmation of your agreement with, the Pharmacy Provider Provisions, and
   (ii) constitute a representation by you that such claim is a true account of a prescription medication or device dispensed or professional advice provided by you to a Cardholder.

This Agreement shall be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.

Dated the _____ day of _____, 20____.

_____
(write legal name of Pharmacy above)

By: _____
signature

Print Name _____

Print Title

_____
I have the authority to bind the above-named Pharmacy

Note: NexgenRx requires the signature of the Pharmacy's signing officer accredited with the relevant Provincial Licensing Authority

Pharmacy Provider Number

(to be assigned by NexgenRx)

This Agreement is hereby accepted as of the above noted date.
NexgenRx Inc.

_____

Cindy Robinson, C.A.O.
I have the authority to bind NexgenRx Inc.

CHANGE OF OWNERSHIP

YOUR PROVIDER NUMBER IS LINKED TO YOUR BANKING INFORMATION. PLEASE AMEND YOUR COMPUTER.

Attach Voided Cheque Here
(see section 4)

Note: If such cheque is not preprinted with your legal or operating name, address and bank account number, then a letter from your bank confirming the name in which your account is held, your account number and the name(s) of your authorized signing officer(s) is required.