MediSystem Pharmacy
A SHOPPERS DRUG MART COMPANY

# CHANGE OF ADDRESS REQUEST FORM

**If you wish to update your MediSystem Account's billing address, please fill out this form.**

**Account Number:** _____

**Resident Name:** _____

**Facility Name:** _____

**POA Name:** _____

***Please provide contact numbers for verifications and payment confirmations.***

**Cell:** _____ **Home:** _____ **Business:** _____ **ext.:** _____

*(If you wish to receive monthly statements and communications by email, please contact our MediSystem Accounts Receivable Team)*

**Billing Address:**

_____

*(Street Address, Unit)*

_____

*(City, Province)*

_____

*(Postal Code)*

---

Should you require more information, please contact the MediSystem Accounts Receivable Team with the contact information below:

243 Consumers Road
Toronto, ON M2J 4W8
Tel: 416-499-9760
Toll-free: 1-866-900-6900
Fax: 416-443-6234
General Email: accounting@imedisystem.com

**How to submit this form to accounting:**

1. Download the PDF form onto your computer
2. Complete fillable fields and ensure all information is correct
3. Once you have completed and checked the information hit the "Submit" button on the bottom of this page. This will then open up an email window that can be sent to accounting.

Submit