Alberta Government

Bulletin

Alberta Health Care Insurance Plan

Number: Gen 145	Date: February 6, 2024
Subject: Claims for benefits for insured medical services provided where the patient is a resident who is not yet registered under the AHCIP or who has coverage under a P/T Plan but does not present their health card (known as "good faith claims")	**Reference: N/A**

To: All physicians, billing staff, and registration staff

This Bulletin replaces Bulletin Gen 142.

Alberta Health recognizes that there are:

1) patients who, for a variety of reasons, may not be able to provide conventional proof of residency or registration under the Alberta Health Care Insurance Plan (AHCIP) because they lack the usual identification (e.g., drivers' licenses, passports, bills showing a fixed address, etc.) when they present to obtain medically required services, but who are very likely "residents" for the purposes of registration and coverage under the AHCIP; and
2) patients from another province or territory of Canada (P/T) that has a medical reciprocal (MR) agreement with Alberta Health that are covered by the health insurance plan of that P/T (P/T Plan), but who have not presented a valid and active P/T health insurance card.

Changes to the Claims Assessment System (CLASS) are now complete. Subject to this Bulletin and the *Alberta Health Care Insurance Act* (AHCIA), Alberta Health will pay benefits in respect of medically required services provided to:

1) a resident who, at the time of service, is not yet registered with the Minister under the *Health Insurance Premiums Act* for coverage under the AHCIP; or
2) a patient from another P/T that has a MR agreement with Alberta Health that is covered by the health insurance plan of that P/T, but who has not presented a valid and active P/T Plan card;
(commonly referred to as a "good faith" claim) if the following requirements are met:

    1) all steps have been taken under Appendix A to this Bulletin, either by the physician or through their staff and/or facility staff, to confirm the patient had valid and active AHCIP or P/T Plan coverage and, notwithstanding current AHCIP or P/T Plan coverage could not be verified, the physician (either personally or through their staff and/or facility staff) concluded the patient is a resident or covered under the P/T Plan;
    2) the physician or their staff or facility staff will, if requested, provide to Alberta Health any of the information they relied on to conclude the patient was a resident or had active P/T Plan coverage notwithstanding the lack of usual identification; and
    3) in respect of patients who are residents, the physician or their staff or facility staff has informed the patient how to register under the AHCIP.

Please complete the following with the identified information on your claim:

1. CIB1 – Claim data segment which must contain:
    - Prac ID, Health Service Code (HSC), Date of Service (DOS), Diagnostic code(s), Modifiers, Facility Number, Business Arrangement, etc.
    - Good Faith Indicator field set to "Y".
    - Service Recipient ULI is blank.
    - Service Recipient Registration number is blank

2. CPD1 – Person data segment which must contain:
    - Patient demographic information collected from the patient as follows: Last Name (Surname), First Name, Date of Birth, Gender, and complete Address including postal code.
        - For Address: Do not use dashes, abbreviations or punctuation, or the claim will be refused (e.g., 4156 Northview Crescent Calgary AB CAN T1X 1M9).

To ensure that your claim is assessed and paid as soon as it is received by Alberta Health, text should **not** be added to the claim unless required by the health service code. Adding text to claims where text is not required by the HSC may delay the assessment and payment of the claim.

For clarity, this commitment excludes medically required services provided to the ineligible patients listed in Appendix B to this Bulletin.

For the insured medical services provided between April 1, 2022 and the date of this Bulletin, the Minister will consider that "extenuating circumstances" exist pursuant to section 7 of the *Claims for Benefits Regulation,* such that the 90-day rule for claims submission in that section does not apply.

All other terms in this Bulletin shall have the meanings given to them in the AHCIA and its regulations, as the case may be.

In addition, this Bulletin is subordinate to, and is intended to align with, the AHCIA and its regulations. In the case of conflict between the Bulletin and the legislation, the Bulletin will be interpreted to the extent possible so as to eliminate the conflict. If it is not possible to so interpret the Bulletin, the legislation will prevail.

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APPENDIX A
Registration Processes

Physicians, either personally or through their staff and/or facility staff, have followed the applicable procedures in the following to verify a patient has valid and active AHCIP or P/T Plan coverage:

- The Physician's Resource Guide; and
- The Provincial Registration Standards and Practices Manual;

as both may be amended from time to time.

Physicians, either personally or through their staff and/or facility staff, have also contacted the following to verify if a patient has valid and active AHCIP coverage:

1. Alberta Health's 24-hour Interactive Voice Response (IVR) inquiry service, available at 1-888-422-6257, which enables physicians and their staff to verify if a patient's Alberta Personal Health Number (PHN) is valid and active;
2. Alberta Netcare, which enables physicians, their staff, and acute care facility staff to verify if a patient's PHN is valid and active;
3. The facilities' Admission, Discharge, Transfer (ADT)/Clinical Information System (CIS) systems (Connect Care, Meditech, etc.), which assist physicians to verify if a patient's PHN is valid and active; and
4. The facilities' registration area and/or health records department, with which physicians and their staff can connect directly, which will provide the patient's valid and active PHN.

If the above are unsuccessful in verifying AHCIP coverage, the physician or staff person will have the patient call the AHCIP General Inquiries line at 780-427-1432 within Edmonton or for the rest of Alberta toll-free to 310-000, then 780-427-1432. The agents can confirm the patient's status, update records, or send out an application for coverage.

APPENDIX B
Ineligible Patients

The table below identifies individuals who, although they may be located in Alberta and receive medically required services from a physician, are not eligible for coverage under either the AHCIP or under another PT health insurance plan or a MR agreement, such that corresponding physician claims are not payable through the AHCIP. The table provides summary information on how a physician can submit claims and be paid for providing medically required services to these individuals. Refer to the *Alberta Health Care Insurance Act* and regulations, AHCIP Bulletin Gen 92 and the Physician's Resource Guide for further information.

Individuals who are not eligible	How to bill
Federal Penitentiary Inmates	Individuals who are inmates in a federal penitentiary are provided health coverage by the federal government for the period of their incarceration. Medically required services provided to patients in this category should be billed directly to the federal government or other secondary insurer, as applicable. The AHCIP cannot pay any claims for benefits submitted by physicians for medically required services provided to individuals who are inmates in a federal correction institution when the services were provided. For medically required services provided to patients in federal penitentiaries, physicians should contact the relevant federal penitentiary and ask to speak to its director of health services, who will provide information concerning how claims are to be submitted and other payment information (i.e., rates).
Members of the Canadian Armed Forces (CAF)	Members of the CAF are provided health coverage by the federal government until these members are discharged or otherwise leave the CAF. The AHCIP cannot pay any claims submitted by physicians for medically required services provided to active duty members of the CAF. Medavie Blue Cross is currently the federal government's designated administrator responsible for processing claims for medically required services provided to CAF members, including the adjudication and payment of eligible health care provider invoices. Please direct all medical billing for medically required services provided to CAF members to Medavie Blue Cross for processing. For more information about Medavie Blue Cross and how to bill for providing medically required services to CAF members, please refer to their website at: www.medaviebc.ca.

Individuals who are not eligible	How to bill
Individuals who have coverage provided by the Province of Quebec	Currently, the province of Quebec does not have a MR agreement with Alberta. Therefore, the AHCIP cannot pay any claims submitted by physicians for medically required services provided to individuals who have public health insurance coverage from the province of Quebec. In order to be paid for providing medically required services to an individual who has coverage provided by the province of Quebec, the physician or the patient will need to complete a Quebec Claim for Physician/Practitioner Services form found on the Régie de l'assurance maladie du Québec (RAMQ) website and submit the claim directly to Quebec's health authorities for adjudication and payment.
Individuals who have chosen to opt out of the AHCIP.	An individual may choose to declare to the Minister of Health that they no longer wish to have AHCIP coverage for either themselves and/or their minor dependents and wish to be opted-out of the AHCIP. The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an opted-out individual. In such circumstances, the physician is required to determine the fees payable for the medically required services with the opted-out individual and to bill the opted-out patient directly for the provided services.
Non-residents of Canada (e.g. tourists or others not legally entitled to remain in Canada beyond a certain date or time period and are not entitled to study or work in Alberta)	Non-residents of Canada who are not eligible for AHCIP coverage are individuals who have entered Canada on a tourist visa or other temporary visa that does not allow the visa holder to study or work while in Alberta and requires the visa holder to leave Canada by a set date or set time period. Non-residents of Canada do not include Ukrainian nationals who are eligible for coverage under Alberta's Ukrainian Evacuee Temporary Health Benefits Program (UETHBP). The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an individual who is a non-resident of Canada. In such circumstances the physician will be required to determine the fees payable for the medically required services with the non-resident individual and to bill the non-resident individual directly for the provided services.

Individuals who are not eligible	How to bill
Individuals who have unproven coverage from another P/T health insurance plan or who are seeking medically required services in Alberta that are not covered by the MR agreement.	If a valid and active provincial or territorial health insurance card is not presented, or if the requested medically required service is not eligible under the MR agreement, the physician should bill the patient directly. Patients who cannot provide a valid and active provincial or territorial health insurance card are directly responsible for the cost of the medically required services provided by an Albertan physician. The physician should provide the patient with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 and the patient may submit the claim to their home province's or territory's health insurance plan for reimbursement.
Temporary residents, such as foreign workers, students and their dependents, who present an Alberta health care card with a past expiry date.	Individuals who have entered Alberta from outside of Canada with a visa allowing them to temporarily study in Alberta or temporarily work in Alberta for at least 12 months are eligible for AHCIP coverage for the duration of their visa allowing them to study or work remain in Canada. The expiry date of their AHCIP coverage is identified on their Alberta issued health care card. The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an individual after the expiry date identified on their Alberta health care card. Using the tools/methods described above, check to see if these individuals have a valid and active PHN. If not, bill the patient directly before the medically required service is provided when clinically possible. Patients from outside of Canada are directly responsible for the cost of the medically required services provided. If a temporary resident is billed and subsequently found to have AHCIP coverage, they can ask the physician to submit a pay to patient claim to Alberta Health for reimbursement.
Individuals who are Ukrainian nationals who have entered or remain in Alberta or Canada due to the armed conflict in Ukraine.	Evacuees from Ukraine who have entered or remained in Alberta and Canada as a result of the ongoing armed conflict in Ukraine are required to be registered under the Government of Alberta's Ukrainian Evacuee Temporary Health Benefits Program (UETHBP) in order to obtain coverage for medically required services while residing in Alberta. Once an eligible Ukrainian national is registered in the UETHBP they will be issued a PHN specific to that program. Alberta Health will pay claims to physicians for medically required services provided to a Ukrainian with a valid and active PHN issued pursuant to the UETHBP.

Individuals who are not eligible	How to bill
	Where an individual submits a PHN issued per UETHBP, it can be verified using the tools/methods described above.
Individuals who have entered Alberta and Canada as refugees	The Interim Federal Health Program (IFHP) provides coverage for individuals who have entered Canada as refugees and are in the process of obtaining refugee status so as to remain in Canada (Refugee Claimants), as well as those individuals who have been denied refugee status (Failed Refugee Claimants), but are appealing the decision. The AHCIP cannot pay any claims submitted by physicians for medically required services provided to Refugee Claimants and Failed Refugee Claimants.
WCB Patients	Claims for medically required services provided by a physician to Alberta residents in relation to workplace injuries are not payable by the AHCIP and must be submitted directly to the Workers' Compensation Board (WCB) – Alberta for adjudication and payment.