Allied Health Practitioner's Resource Guide

Alberta

For use by allied practitioners and their office staff as a guide for handling fee-for-service claims to the Alberta Health Care Insurance Plan.

Alberta Government

Ministry: Alberta Health
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Title of publication: Alberta Health Allied Health Practitioner's Resource Guide

The Allied Health Practitioner's Resource Guide is intended solely as a reference tool and is not a legal document. In the event of conflict between information contained in this guide and any applicable legislation, including the *Alberta Health Care Insurance Act* and/or any Regulations thereunder, the applicable legislation will prevail.

Contents

Introduction

The purpose of this guide is to help allied health practitioners (dental surgeons, optometrists, podiatrists, and podiatric surgeons) and their billing staff prepare claims for services that are insured under the Alberta Health Care Insurance Plan (AHCIP), and follow up, if necessary, after claims have been assessed.

The information in this guide will help you:

- Obtain a practitioner identifier and be added to or create a new business arrangement number,
- Understand what must be included on all claims to the AHCIP,
- Ensure that data you enter on a claim is up to date,
- Verify a patient's health care coverage, and
- Understand the Alberta Health Statement of Assessment and Statement of Account.

This guide is designed for use in conjunction with the Schedule of Benefits. Current copies of the Schedule of Benefits are available online at https://www.alberta.ca/fees-health-professionals.aspx.

Whenever the Schedules are updated, new versions are posted on our website for your use.

1.0 AHCIP Basics for the Practitioner

Alberta allied health practitioners who submit claims to the AHCIP must have a practitioner identification number (PRAC ID) and business arrangement with Alberta Health. Practitioners who do not submit claims but refer patients to other practitioners who submit claims to the AHCIP do not need a business arrangement; however, they must have a PRAC ID for referral purposes.

The Provider Relationship and Claims unit of Alberta Health processes applications for PRAC IDs and maintains the related information (business arrangements, skill, addresses, etc.) that is vital to processing practitioner claims.

1.1 Claiming Services from the AHCIP

Allied health practitioners may submit claims to the AHCIP for insured services provided to eligible Alberta residents (Section 2.1 – Alberta Residents).

Claims are submitted using the electronic H-Link method, either by an existing accredited submitter or the practitioner can apply to become their own submitter. (Section 1.6.4 - The Business Arrangement and the Submitter.)

1.2 Services Not Claimable from the AHCIP

- Services that are not insured may not be claimed from the AHCIP.
- Allied health practitioners may not claim for any service they provide to their children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner, or any person who is dependent on the practitioner for support.
- When one allied health practitioner sends a member of his/her family to another practitioner, the second practitioner may not claim for a consultation. A referral from a patient's family member is not considered a formal referral for the purposes of billing a consultation service.
- Claims that are the responsibility of the Workers' Compensation Board (WCB) must not be submitted to the AHCIP. They must be submitted directly to the WCB. (Section 4.5 – Workers' Compensation Board (WCB) claims.)

1.3 Registering as a New Practitioner

An allied health practitioner registering with Alberta Health for the first time must complete a Practitioner Request form – AHC11234. When registered, the new practitioner is assigned a Practitioner Identification number (PRAC ID).

The PRAC ID is entered on a claim to the AHCIP to identify the practitioner who provided the service. When applicable, it also identifies the practitioner who has referred a patient to another practitioner for an insured service. The Practitioner Request Form and instructions for completing the form are available online at: https://www.alberta.ca/health-professional-business-forms.aspx.

As all business forms are updated periodically, it is recommended to use the most current version located on the Alberta Health website.

> If you are a **salaried or contract allied health practitioner** who does not submit claims to the AHCIP but refers patients to practitioners who do bill the AHCIP, you should still register as a referring practitioner. Be sure to attach all required documentation. No other forms are required.

Alberta Health does **not** register **out-of-province** allied health practitioners and service providers for the purpose of receiving practitioner IDs to provide virtual health care services to Albertans. Practitioner ID numbers are only granted to allied health practitioners and providers that are physically working in the province of Alberta. For more information, please see section 4.3 Virtual Health Claims.

1.4 Other Forms a Practitioner May Need to Complete

An allied health practitioner who is already registered and needs to change some of the information about their practice (business mailing address, business arrangement, skill, submitter, banking information, etc.) will need to complete one or more of the forms listed below.

Facility Registration AHC0910A	To set up a new facility, end a facility, or change information on an existing facility. The CPSA Clinic registration letter must accompany this form.
Business Arrangement and Relationships Application AHC11236	To set up a new business arrangement, change or end information on an existing business arrangement, or to change information about your relationship with an existing business arrangement. In addition, this form is used to authorize an accredited submitter to submit claims on your behalf, or to change from one submitter to another.
Notification of Business Address Change AHC11459	To update your current business address to a new business address.
Direct Deposit Request AHC1143	To change the direct deposit banking information for your claim payments.

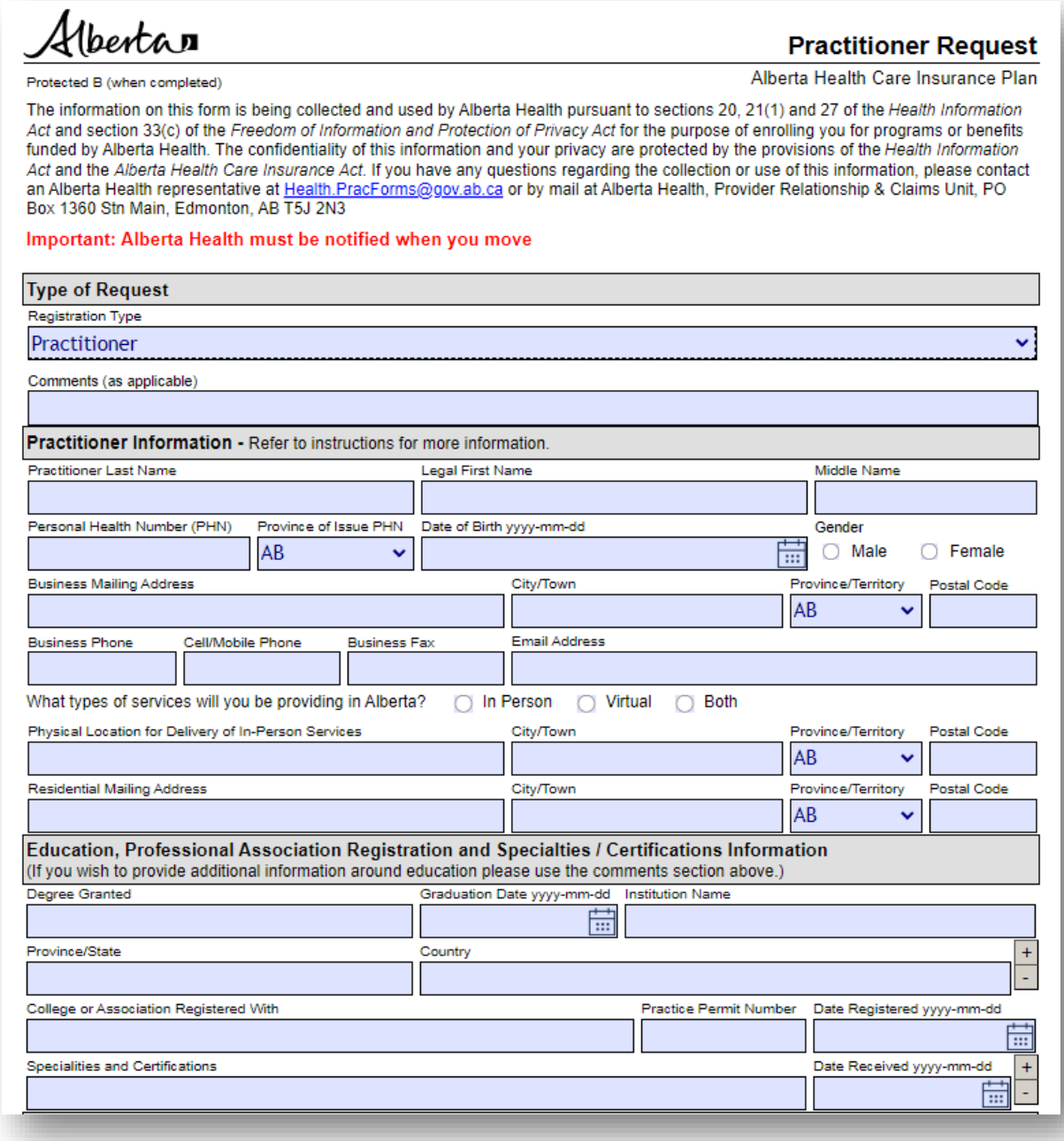
To avoid delays in the processing and payment of claims, please advise Alberta Health of all changes to practitioner information in advance of the date the changes are effective.

If you use your home address as your business mailing address, please inform us if you change your home

1.5 Sample Forms

The following are samples of the various forms an allied health practitioner may require, as listed above. The mailing address and fax number for submitting completed forms are indicated on each form. When you need to submit any of these forms, you can complete and print them from our website at: https://www.alberta.ca/health-professional-business-forms.aspx.

1.5.1 Practitioner request form (AHC11234) – sample



Alberta

Practitioner Request

Protected B (when completed)

Alberta Health Care Insurance Plan

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of enrolling you for programs or benefits funded by Alberta Health. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative at Health.PracForms@gov.ab.ca or by mail at Alberta Health, Provider Relationship & Claims Unit, PO Box 1360 Stn Main, Edmonton, AB T5J 2N3

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Practitioner

Comments (as applicable)

Practitioner Information - Refer to instructions for more information.

Practitioner Last Name | Legal First Name | Middle Name

Personal Health Number (PHN) | Province of Issue PHN: AB | Date of Birth yyyy-mm-dd | Gender: Male, Female

Business Mailing Address | City/Town | Province/Territory: AB | Postal Code

Business Phone | Cell/Mobile Phone | Business Fax | Email Address

What types of services will you be providing in Alberta? In Person, Virtual, Both

Physical Location for Delivery of In-Person Services | City/Town | Province/Territory: AB | Postal Code

Residential Mailing Address | City/Town | Province/Territory: AB | Postal Code

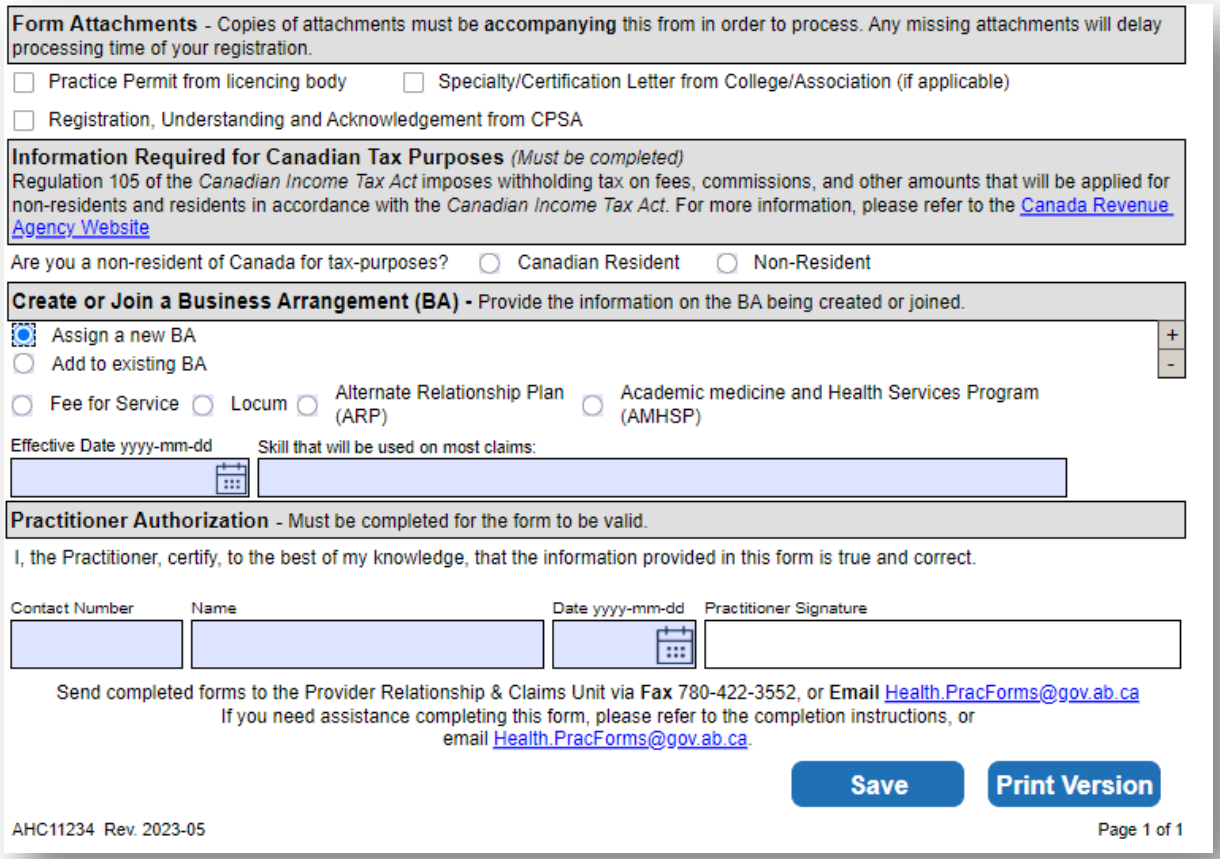
Education, Professional Association Registration and Specialties / Certifications Information
(If you wish to provide additional information around education please use the comments section above.)

Degree Granted | Graduation Date yyyy-mm-dd | Institution Name

Province/State | Country

College or Association Registered With | Practice Permit Number | Date Registered yyyy-mm-dd

Specialities and Certifications | Date Received yyyy-mm-dd



Form Attachments - Copies of attachments must be **accompanying** this from in order to process. Any missing attachments will delay processing time of your registration.

☐ Practice Permit from licencing body ☐ Specialty/Certification Letter from College/Association (if applicable)

☐ Registration, Understanding and Acknowledgement from CPSA

Information Required for Canadian Tax Purposes *(Must be completed)*
Regulation 105 of the *Canadian Income Tax Act* imposes withholding tax on fees, commissions, and other amounts that will be applied for non-residents and residents in accordance with the *Canadian Income Tax Act*. For more information, please refer to the Canada Revenue Agency Website

Are you a non-resident of Canada for tax-purposes? ○ Canadian Resident ○ Non-Resident

Create or Join a Business Arrangement (BA) - Provide the information on the BA being created or joined.

◉ Assign a new BA
○ Add to existing BA

○ Fee for Service ○ Locum ○ Alternate Relationship Plan (ARP) ○ Academic medicine and Health Services Program (AMHSP)

Effective Date yyyy-mm-dd

Skill that will be used on most claims:

Practitioner Authorization - Must be completed for the form to be valid.

I, the Practitioner, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number | Name | Date yyyy-mm-dd | Practitioner Signature

Send completed forms to the Provider Relationship & Claims Unit via **Fax** 780-422-3552, or **Email** Health.PracForms@gov.ab.ca
If you need assistance completing this form, please refer to the completion instructions, or email Health.PracForms@gov.ab.ca.

Save Print Version

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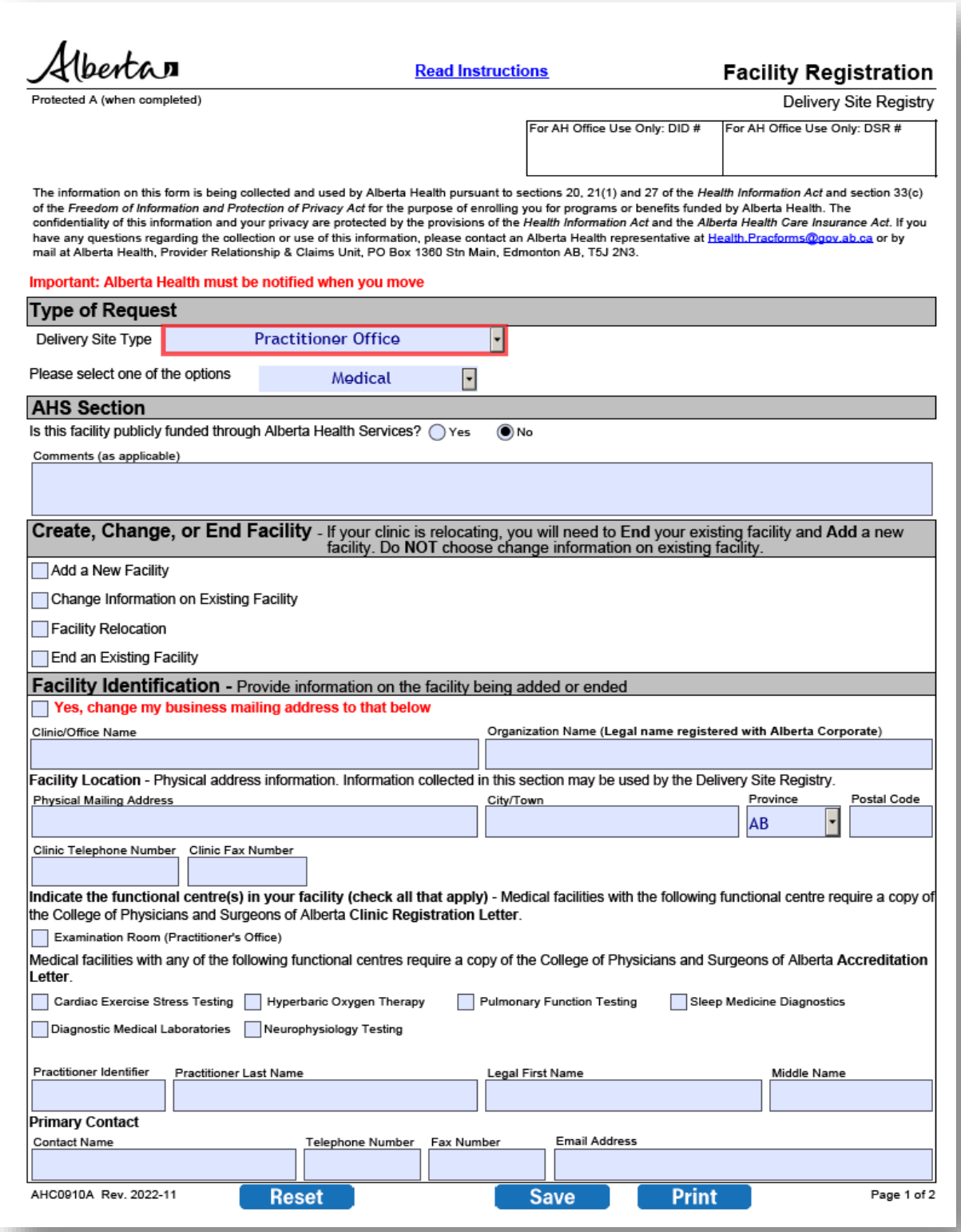
1.5.2 Facility registration form (AHC0910A) – sample



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Read Instructions

Facility Registration

Protected A (when completed)

Delivery Site Registry

For AH Office Use Only: DID #	For AH Office Use Only: DSR #

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of enrolling you for programs or benefits funded by Alberta Health. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative at Health.Pracforms@gov.ab.ca or by mail at Alberta Health, Provider Relationship & Claims Unit, PO Box 1360 Stn Main, Edmonton AB, T5J 2N3.

Important: Alberta Health must be notified when you move

Type of Request

Delivery Site Type: Practitioner Office

Please select one of the options: Medical

AHS Section

Is this facility publicly funded through Alberta Health Services? ◯ Yes ◉ No

Comments (as applicable)

Create, Change, or End Facility - If your clinic is relocating, you will need to **End** your existing facility and **Add** a new facility. Do **NOT** choose change information on existing facility.

- ☐ Add a New Facility
- ☐ Change Information on Existing Facility
- ☐ Facility Relocation
- ☐ End an Existing Facility

Facility Identification - Provide information on the facility being added or ended

☐ **Yes, change my business mailing address to that below**

Clinic/Office Name | Organization Name (**Legal name registered with Alberta Corporate**)

Facility Location - Physical address information. Information collected in this section may be used by the Delivery Site Registry.

Physical Mailing Address | City/Town | Province: AB | Postal Code

Clinic Telephone Number | Clinic Fax Number

Indicate the functional centre(s) in your facility (check all that apply) - Medical facilities with the following functional centre require a copy of the College of Physicians and Surgeons of Alberta **Clinic Registration Letter**.

☐ Examination Room (Practitioner's Office)

Medical facilities with any of the following functional centres require a copy of the College of Physicians and Surgeons of Alberta **Accreditation Letter**.

☐ Cardiac Exercise Stress Testing ☐ Hyperbaric Oxygen Therapy ☐ Pulmonary Function Testing ☐ Sleep Medicine Diagnostics

☐ Diagnostic Medical Laboratories ☐ Neurophysiology Testing

Practitioner Identifier | Practitioner Last Name | Legal First Name | Middle Name

Primary Contact

Contact Name | Telephone Number | Fax Number | Email Address

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Practitioner Authorization - Must be completed for the form to be valid.

"To the best of my knowledge, the information provided in this form is true and correct"

Practitioner Name	Date yyyy-mm-dd	Signature

Clinic or Practice Owner Authorization

"To the best of my knowledge, the information provided in this form is true and correct"

Clinic or Practice Owner Name	Date yyyy-mm-dd	Signature

Send completed forms and if applicable, the necessary supporting documentation
to the Provider Relationship and Claims Unit via **Fax** 780-422-3552,

or **email** Health.PracForms@gov.ab.ca

If you need assistance completing this form, please refer to the completion instructions, or

email Health.PracForms@gov.ab.ca

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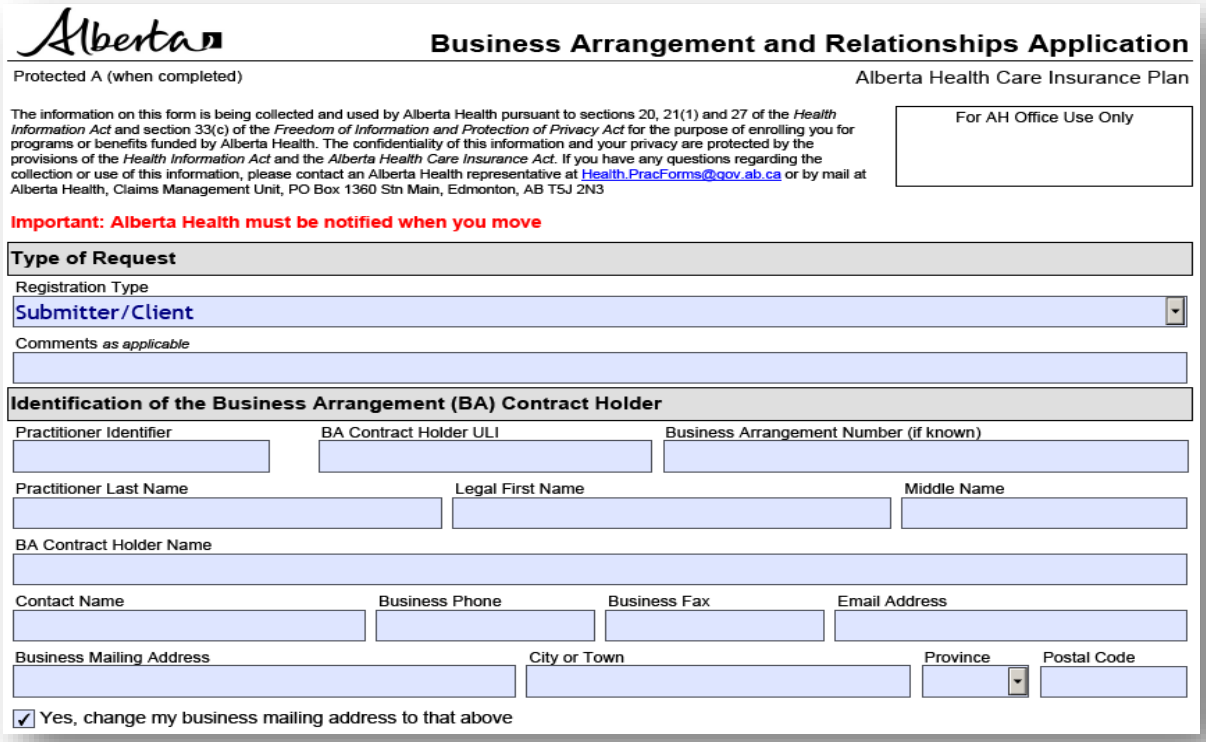
1.5.3 Business arrangement and relationships form (AHC11236) – sample



Alberta

Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of enrolling you for programs or benefits funded by Alberta Health. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative at Health.PracForms@gov.ab.ca or by mail at Alberta Health, Claims Management Unit, PO Box 1360 Stn Main, Edmonton, AB T5J 2N3

For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Submitter/Client

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

Practitioner Identifier | BA Contract Holder ULI | Business Arrangement Number (if known)

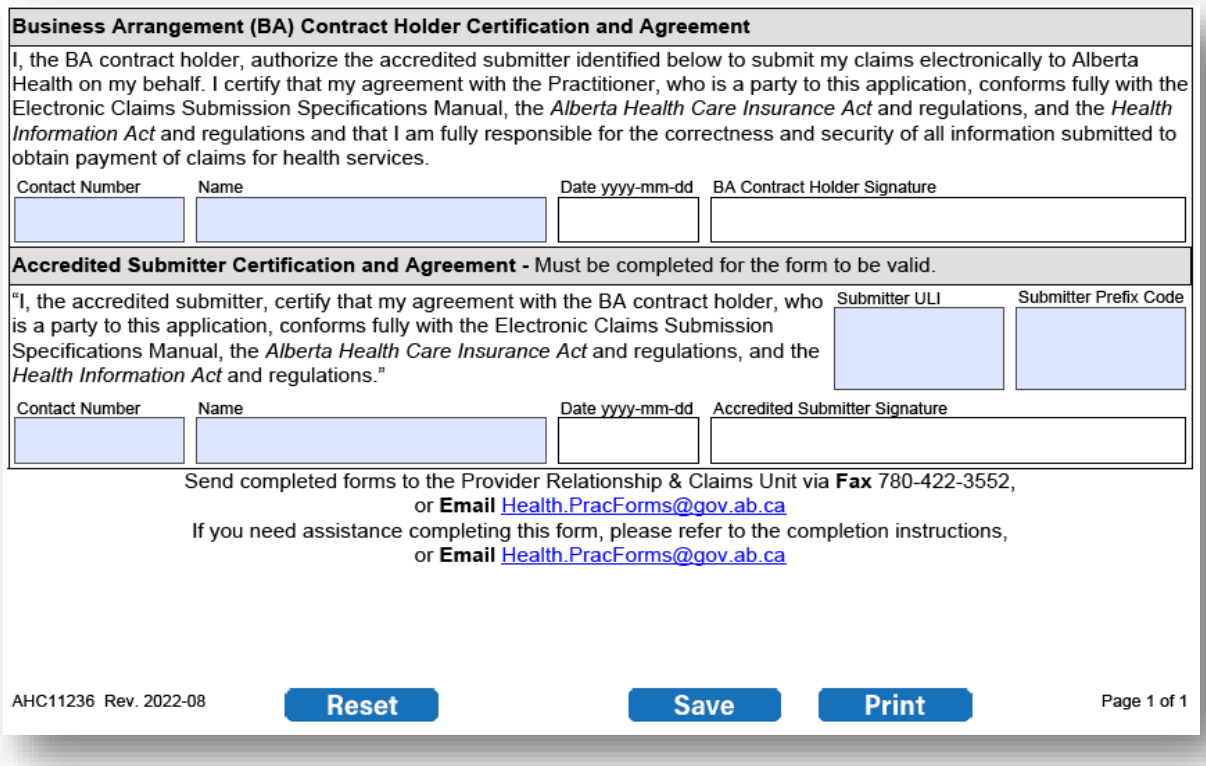
Practitioner Last Name | Legal First Name | Middle Name

BA Contract Holder Name

Contact Name | Business Phone | Business Fax | Email Address

Business Mailing Address | City or Town | Province | Postal Code

☑ Yes, change my business mailing address to that above



Business Arrangement (BA) Contract Holder Certification and Agreement

I, the BA contract holder, authorize the accredited submitter identified below to submit my claims electronically to Alberta Health on my behalf. I certify that my agreement with the Practitioner, who is a party to this application, conforms fully with the Electronic Claims Submission Specifications Manual, the *Alberta Health Care Insurance Act* and regulations, and the *Health Information Act* and regulations and that I am fully responsible for the correctness and security of all information submitted to obtain payment of claims for health services.

Contact Number | Name | Date yyyy-mm-dd | BA Contract Holder Signature

Accredited Submitter Certification and Agreement - Must be completed for the form to be valid.

"I, the accredited submitter, certify that my agreement with the BA contract holder, who is a party to this application, conforms fully with the Electronic Claims Submission Specifications Manual, the *Alberta Health Care Insurance Act* and regulations, and the *Health Information Act* and regulations."

Submitter ULI | Submitter Prefix Code

Contact Number | Name | Date yyyy-mm-dd | Accredited Submitter Signature

Send completed forms to the Provider Relationship & Claims Unit via **Fax** 780-422-3552, or **Email** Health.PracForms@gov.ab.ca

If you need assistance completing this form, please refer to the completion instructions, or **Email** Health.PracForms@gov.ab.ca

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Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Business Arrangement Request

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

○ Practitioner ◉ Professional Corporation (PC) ○ Clinic

Practitioner Identifier | PC/Clinic Name

Practitioner Last Name | Legal First Name | Middle Name

Contact Name | Business Phone | Business Fax | Email Address

Business Mailing Address | City or Town | Province | Postal Code

☐ Yes, change my business mailing address to that above

Create, Change, or End Business Arrangement (BA) - Provide the information on the BA being created or modified.

☑ Assign a new BA

☐ Change BA effective date

☐ Change my BA default skill code

☐ End my relationship with the BA

☑ Change where my statements are sent

BA Number

Send Statement of Account to: Me

Send Statement of Assessment to: Me

Business Arrangement (BA) Contract Holder Certification and Agreement

I, the BA contract holder, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number | Name | Date yyyy-mm-dd | BA Contract Holder Signature

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Practitioner Last Name: | Legal First Name: | Middle Name:

Practitioner Authorization

I, the Practitioner, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number | Name | Date yyyy-mm-dd | Practitioner Signature

(•) Fee for Service ( ) Locum ( ) Alternate Relationship Plan (ARP) ( ) Academic medicine and Health Services Program (AMHSP)

Effective Date yyyy-mm-dd | Skill that will be used on most claims

Business Arrangement (BA) Information - Provide details for the BA

For Direct Deposit Attached is:
(•) **a void cheque**
( ) documentation **from a financial institution** indicating bank, branch transit, and account number.

Make Payment to: Me

Send Statement of Account to: My PC/Clinic | PC/Clinic Name

Business Mailing Address | City or Town | Province | Postal Code

Send Statement of Assessment to: Suppress

Business Arrangement (BA) Contract Holder Certification and Agreement - Must be completed if the Contract Holder is not the Practitioner signing this form.

I, the BA contract holder, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number | Name | Date yyyy-mm-dd | BA Contract Holder Signature

Accredited Submitter Certification and Agreement

"I, the accredited submitter, certify that my agreement with the BA contract holder, who is a party to this application, conforms fully with the Electronic Claims Submission Specifications Manual, the *Alberta Health Care Insurance Act* and regulations, and the *Health Information Act* and regulations."

Submitter ULI | Submitter Prefix Code

Contact Number | Name | Date yyyy-mm-dd | Accredited Submitter Signature

Practitioner Authorization

I, the Practitioner, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number | Name | Date yyyy-mm-dd | Practitioner Signature

Send completed forms to the Provider Relationship & Claims Unit via **Fax** 780-422-3552,
or **Email** Health.PracForms@gov.ab.ca
If you need assistance completing this form, please refer to the completion instructions,
or **Email** Health.PracForms@gov.ab.ca

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Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type

Business Arrangement/Service Provider

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

BA Contract Holder Name

Contact Name | Business Phone | Business Fax | Email Address

Business Mailing Address | City or Town | Province | Postal Code

☐ Yes, change my business mailing address to that above

Create, Change, or End Business Arrangement (BA) - Provide the information on the BA being created or modified.

Practitioner Identifier | Practitioner Last Name | Legal First Name | Middle Name

☐ Add to existing BA

☐ Change my start date with BA

☐ Change the effective date of my BA Number

☐ Change my BA default skill code

☐ End my relationship with the BA

Send completed forms to the Provider Relationship & Claims Unit via **Fax** 780-422-3552,
or **Email** Health.PracForms@gov.ab.ca
If you need assistance completing this form, please refer to the completion instructions,
or **Email** Health.PracForms@gov.ab.ca

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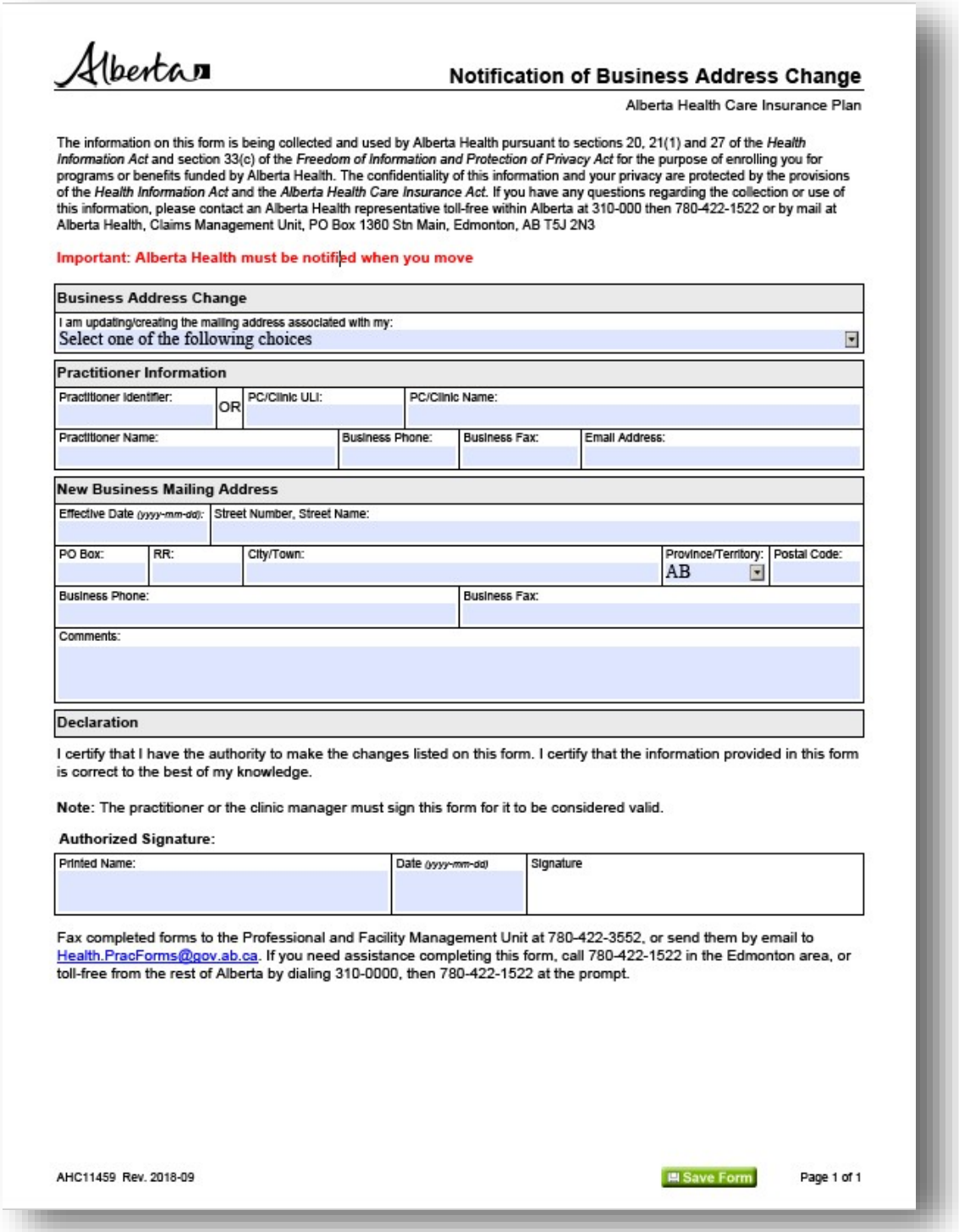
1.5.4 Notification of business address change form (AHC11459) – sample



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Notification of Business Address Change

Alberta Health Care Insurance Plan

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Important: Alberta Health must be notified when you move

Business Address Change

I am updating/creating the mailing address associated with my:
Select one of the following choices

Practitioner Information

Practitioner Identifier:	OR	PC/Clinic ULI:	PC/Clinic Name:

Practitioner Name:	Business Phone:	Business Fax:	Email Address:

New Business Mailing Address

Effective Date (yyyy-mm-dd):	Street Number, Street Name:

PO Box:	RR:	City/Town:	Province/Territory:	Postal Code:
			AB	

Business Phone:	Business Fax:

Comments:

Declaration

I certify that I have the authority to make the changes listed on this form. I certify that the information provided in this form is correct to the best of my knowledge.

Note: The practitioner or the clinic manager must sign this form for it to be considered valid.

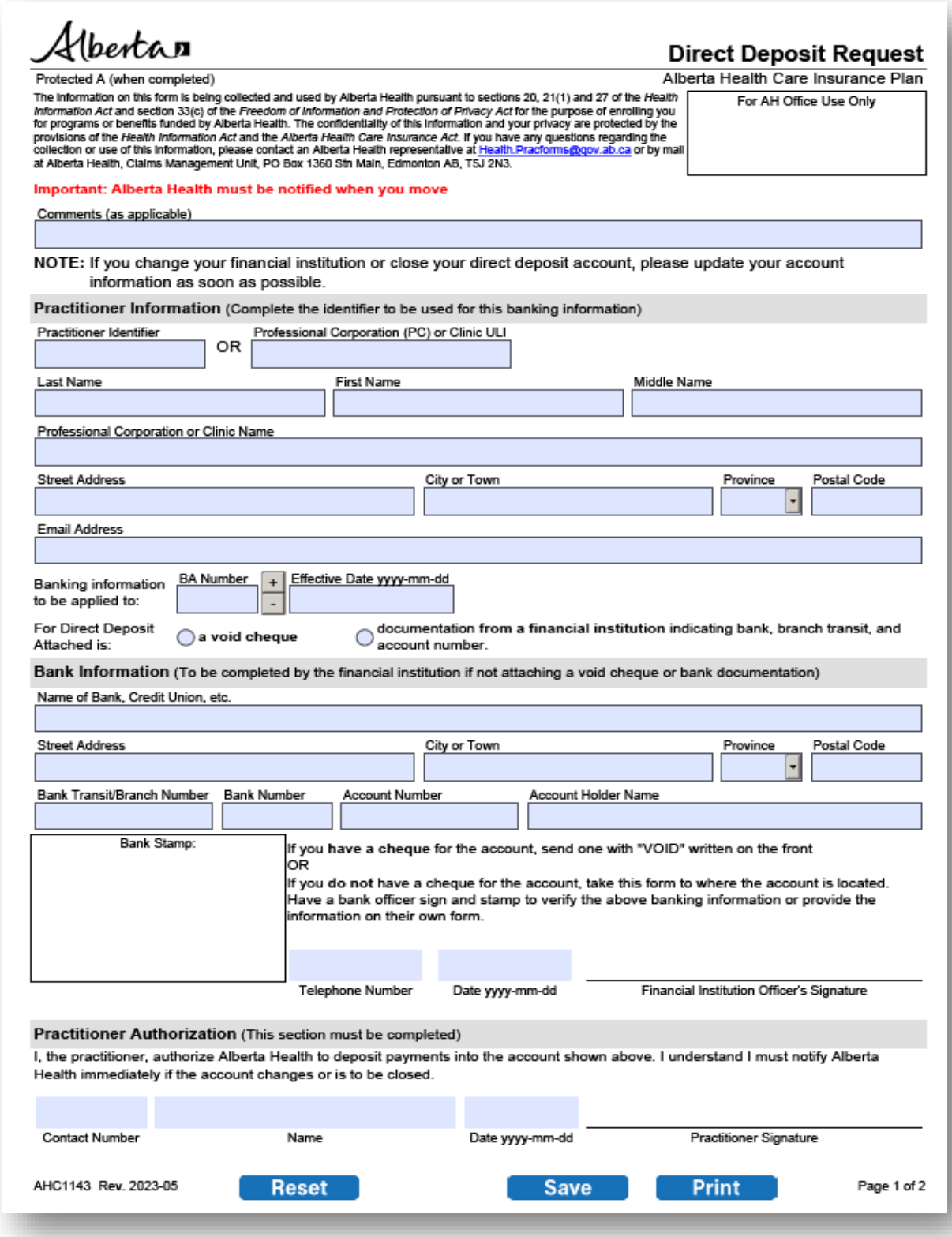
Authorized Signature:

Printed Name:	Date (yyyy-mm-dd)	Signature

Fax completed forms to the Professional and Facility Management Unit at 780-422-3552, or send them by email to Health.PracForms@gov.ab.ca. If you need assistance completing this form, call 780-422-1522 in the Edmonton area, or toll-free from the rest of Alberta by dialing 310-0000, then 780-422-1522 at the prompt.

AHC11459 Rev. 2018-09 Save Form Page 1 of 1

1.5.5 Direct deposit request (AHC1143) – sample



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Direct Deposit Request

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Comments (as applicable)

NOTE: If you change your financial institution or close your direct deposit account, please update your account information as soon as possible.

Practitioner Information (Complete the identifier to be used for this banking information)

Practitioner Identifier | OR | Professional Corporation (PC) or Clinic ULI

Last Name | First Name | Middle Name

Professional Corporation or Clinic Name

Street Address | City or Town | Province | Postal Code

Email Address

Banking information to be applied to: | BA Number | + | - | Effective Date yyyy-mm-dd

For Direct Deposit Attached is: ◯ **a void cheque** ◯ **documentation from a financial institution** indicating bank, branch transit, and account number.

Bank Information (To be completed by the financial institution if not attaching a void cheque or bank documentation)

Name of Bank, Credit Union, etc.

Street Address | City or Town | Province | Postal Code

Bank Transit/Branch Number | Bank Number | Account Number | Account Holder Name

Bank Stamp:

If you **have a cheque** for the account, send one with "VOID" written on the front
OR
If you **do not** have a cheque for the account, take this form to where the account is located. Have a bank officer sign and stamp to verify the above banking information or provide the information on their own form.

Telephone Number | Date yyyy-mm-dd | Financial Institution Officer's Signature

Practitioner Authorization (This section must be completed)

I, the practitioner, authorize Alberta Health to deposit payments into the account shown above. I understand I must notify Alberta Health immediately if the account changes or is to be closed.

Contact Number | Name | Date yyyy-mm-dd | Practitioner Signature

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1.6 The Business Arrangement

To submit claims for insured services, an allied health practitioner must have or be part of a business arrangement with Alberta Health. A business arrangement is an agreement to establish the arrangement for payment of health services provided. It identifies:

- Who is to be paid.
- Where Alberta Health statements are to be sent.
- Which submitter is authorized to submit claims for that business arrangement.

A business arrangement number **must** appear on all claim submissions. An allied health practitioner registering with Alberta Health for the first time provides their business arrangement details when they complete the Practitioner Request form – AHC11234.

An allied health practitioner may have more than one business arrangement, and a business arrangement may have more than one participating practitioner. All practitioners participating in the same business arrangement must be linked to that business arrangement in order to claim for insured services.

To make a change to an existing business arrangement or to request a new business arrangement, complete the Business Arrangement and Relationship Application form – AHC11236. If your business arrangement is no longer in use, please contact Alberta Health at health.pracforms@gov.ab.ca.

If an allied health practitioner participates under someone else's business arrangement, Statements of Assessment/Account or any other payment information can only be provided to the Contract Holder – the individual, organization or Professional Corporation who entered into the business arrangement with Alberta Health.

1.6.1 The business arrangement and the practitioner's professional corporation

If you are a professional corporation your Alberta Health statements should reflect this status and your payments should be directed to your corporation. To do this, the corporation must be registered with Alberta Health and must have a business arrangement. You will need to complete the following two forms:

- Business Arrangement and Relationship Application Form – AHC11236. This form identifies any other practitioner(s) who will also be billing through the business arrangement number (e.g. a clinic).
- Notification of Business Address Change Form – AHC11459.

1.6.2 The business arrangement and the practitioner's default skill

The default skill is the **most appropriate skill** used by allied health practitioners to perform most services. Practitioners with multiple skills must designate a default skill for claim submission purposes.

- A new practitioner with more than one skill indicates their default skill when completing the Practitioner Request form – AHC11234.
- As applicable, practitioners completing the Business Arrangement and Relationship Application form – AHC11236 also indicate their default skill.

When the Skill Code field on a claim to the AHCIP is left blank, the claim is automatically processed using the default skill.

1.6.3 The business arrangement and direct deposit

Payments to allied health practitioners are made electronically via direct deposit. Any changes to direct deposit information must be reported to Alberta Health. This ensures payments are deposited into the correct account in a timely manner.

- When a new or registered practitioner is setting up a new business arrangement, they provide their direct deposit information for that new business arrangement by completing a Business Arrangement and Relationship Application form – AHC11236.
- When a new practitioner is joining an existing business arrangement, the direct deposit provision already established for that business arrangement applies.
- A registered practitioner who wishes to add or change their direct deposit information for an existing business arrangement must complete a Direct Deposit Request form - AHC1143.

When payments are to be deposited into a chequing account, you must attach a void cheque to the request. When payments are to be deposited to a savings account, please attach documentation from your financial institution indicating the branch transit, bank and account number. **Only** the contract holder for the business arrangement can authorize banking information.

> Completed forms and void cheques can be faxed to 780-422-3552 or emailed at Health.PracForms@gov.ab.ca; however, the pre-printed bank numbers on the cheque may not be legible when received. Please ensure banking information is legible; otherwise, the processing of your request may be delayed.

1.6.4 The business arrangement and the submitter

Claims are sent to the AHCIP via an accredited submitter using the electronic H-Link method. All business arrangements **must** have an accredited submitter attached to them for claims to be submitted for payment.

If you are a new allied health practitioner, you must determine if you will be sending your claims through an existing submitter or if you wish to become your own submitter and use the H-Link claim submission method.

- If you are joining an existing business arrangement, the submitter for that business arrangement will handle your claims.
- If you are setting up your own practice or clinic, you will need to obtain the services of an accredited submitter; or you can apply to become your own submitter.
  - If you are using an existing accredited submitter, you and your submitter will need to complete a Business Arrangement and Relationships Application form – AHC11236, with Registration Type as Submitter/Client.
  - If you want to be your own submitter, you will need to complete an H-Link Application for Submitter Role - AHC2210.

More information about obtaining the services of an accredited submitter or becoming your own submitter is available by calling H-Link Application Support in Edmonton at 780-644-7643. To call toll-free in Alberta, dial 310-0000 then enter 780-644-7643 when prompted. You can also send an email to health.hlink@gov.ab.ca.

> If you change submitters, we strongly recommend you set up a new business arrangement number for the new submitter. If you choose **not** to set up a new business arrangement for the new submitter, to avoid reconciliation problems, be sure Alberta Health has received and processed **all** claims, including resubmissions, from the old submitter **before** you change to the new submitter.

1.7 Registering Your Facility

If you are setting up a brand-new office, clinic, or other facility, you must register the facility with Alberta Health. Facility registration identifies the physical location (provider office, diagnostic imaging facility, etc.) where health services are routinely performed, as well as any functional centre(s) within the facility (examination room, etc.). Facility numbers are only provided for locations where patients are seen in person. If you are providing virtual only services from your home, a facility number will not be issued.

- Each facility is assigned a facility number. This number is address-linked (i.e., not transferable to another physical location) and remains the same no matter how many practitioners work out of the location. Claims for services provided in the facility must include the facility number.
- Some facilities will require a letter from the CPSA (Clinic registration letter) indicating that the facility is accredited/approved to perform its associated services such as diagnostic imaging, stress testing, and pulmonary function.
- Medical facilities with the functional centre code Examination Room require a copy of the College of Physicians and Surgeons of Alberta Clinic Registration Letter.
- Nurse practitioners are not required to apply and submit a facility registration form if there are no practicing practitioners available (medical, dental, and optometry). If there are no practitioner's present, then a CPSA clinic registration letter is not required as a facility number will not be assigned. If Netcare access is required, then they are to contact ehealthsupport@cgi.com for requests.

1.8 Changing the Location of Your Practice

Facility numbers cannot be transferred when you change locations. When you change the physical location of your practice, you will also have to change your facility number. Notify the Provider Relationship and Claims unit at health.pracforms@gov.ab.ca or fax the completed Facility Registration form - AHC0910A to Alberta Health at 780-422-3552.

1.9 Mandatory Address Reporting

Alberta Health must be notified in advance of any changes to your business mailing address. You may do this by completing the Notification of Business Address Change form - AHC11459 available on the Government of Alberta website.

If your information is not kept current, you risk not receiving your Statements of Assessment and/or Statements of Account.

1.10 Buying an Existing Practice or Clinic

If you are buying an existing practice or clinic, you will need to change all records that refer to the previous owner. The following forms need to be completed:

Business Arrangement and Relationships Application AHC11236	To set up a new business arrangement and if other practitioners will also be submitting claims under your new business arrangement.
Facility Registration AHC0910A	If you need to change the facility or governing stakeholder name.
Notification of Business Address Change AHC11459	To identify the name of the clinic or professional corporation.

If you need more information about Alberta Health requirements when purchasing an existing practice, contact the Provider Relationship and Claims unit at health.pracforms@gov.ab.ca.

2.0 Patient Basics - Eligibility

2.1 Alberta Residents

Under Alberta legislation, a resident of Alberta is defined as a person who is legally entitled to be or to remain in Canada makes his/her permanent home in Alberta and is ordinarily present in Alberta. It does not include tourists, transients or visitors to Alberta or Canada.

Alberta residents are required by law to register themselves and their dependants with Alberta Health. Every resident who is eligible for coverage receives a personal health number (PHN) and an Alberta personal health card that displays their PHN.

When registering for the first time or when returning to Alberta, residents must provide Alberta Health proof of the following before their eligibility for coverage can be determined:

- Identity – confirms who they are (eg. Alberta ID or driver's licence, passport)
- Legal entitlement to be in Canada – confirms legal status to be in Canada (eg. Canadian birth or citizenship certificate, passport, status card, Permanent Residence Card, work or study permit)
- Alberta residency – confirms they live in Alberta and are a resident (eg. utility bill, Alberta ID or driver's licence, insurance documents)

Living in Alberta does not automatically entitle a person to coverage under the AHCIP. The resident must make an application for coverage to the AHCIP at any one of the many Alberta Registry Agent locations offering AHCIP registration services. Applications along with photocopies of supporting documents can also be mailed to Alberta Health at:

Alberta Health
Attention: Alberta Health Care Insurance Plan
P.O. Box 1360, Station Main
Edmonton, AB T5J 2N3

Members of the Canadian Armed Forces and inmates in federal penitentiaries are not covered under the AHCIP. See Section 2.3 Patients who are not Eligible.

2.2 Confirming Patient Eligibility for AHCIP Coverage

Allied health practitioners and/or their staff are responsible to verify that a patient has active AHCIP coverage. To confirm a patient's identity, the patient's personal health card must be seen on each visit. Confirmation of the patient's eligibility is needed prior to submitting a claim to the AHCIP.

Furthermore, to confirm a **new** patient's identity, you must:

- View their personal health care card.
- Request original documentation to support their identity, such as an Alberta driver's licence or photo-identification card.
- Verify the patient's address.

If a patient presents an Alberta personal health card but provides an out-of-province address, call our 24-hour interactive telephone inquiry service.

If there has been an address change or a replacement card is needed, please advise the patient they must call Alberta Health to inform them of the change. In Edmonton, they can call 780-427-1432. Outside Edmonton, residents can call toll-free 310-0000 then 780-427-1432 when prompted. Patients can also update their address at participating registry agent office locations throughout the province, free of charge. A list of participating registry agent office locations is available at https://www.alberta.ca/ahcip-registry-locations.aspx.

Alternatively, practitioner offices can their patient complete a Notice of Change/Update form (AHC2211).

Allied health practitioners and their staff have several options to confirm a patient's eligibility for AHCIP coverage if a patient is unable to provide proof of AHCIP coverage.

- Alberta Health provides a 24-hour interactive telephone inquiry service at 1-888-422-6257 that enables practitioners and their staff to verify if a patient's Alberta PHN is valid and active on the date of service. (Section 2.5 – The Interactive Voice Response (IVR) System.)
- Practitioners and office staff can also verify if a patient's AHCIP coverage is active through Alberta NetCare.
  - Alberta Netcare is the name of our provincial Electronic Health Record System. Information available to practitioners on Alberta Netcare includes eligibility and personal demographics, prescribed medications, allergies and intolerances, immunizations, laboratory test results, diagnostic imaging reports. For more information, see www.albertanetcare.ca.
- At acute care facilities, patient information is available to practitioners in hospital Admission, Discharge, Transfer (ADT)/Clinical Information System (CIS) systems (Connect Care, Meditech, etc.) to assist them with completing their claims.
- Practitioners are also able to connect directly with the hospital registration area and/or health records department of the hospital, which will provide patient registration information.
  - Hospital registration staff follow the Provincial Registration Standards and Practices that were developed jointly by Alberta Health and Alberta Health Services (AHS). Hospital registration staff are responsible to ensure demographic and coverage information is collected and up to date when patients come into an AHS facility for insured medical services.

2.3 Patient who are not Eligible

Allied health practitioners, their staff and/or AHS/AHS contractor staff are responsible for verifying that a patient has active AHCIP coverage, active coverage under another province's/territory's health insurance plan, or coverage under another third-party insurer in order to claim and be paid benefits for providing medically required services to the patient.

The following individuals, although they may be located in Alberta and receive medically required services from a practitioner, are not eligible for coverage under the AHCIP.

If billing the patient directly, the practitioner has the ethical duty to consider the well-being of the patient and to provide care to a patient in an urgent situation regardless of their ability to pay.

Dependents of Canadian Forces personnel and federal penitentiary inmates who reside in Alberta **must register** with Alberta Health.

A practitioner can submit claims and be paid for providing medically required services to these individuals as follows:

Individuals who are not eligible	How to bill
Individuals from another province/territory	• As allied health services are excluded from reciprocal billing under the Medical Reciprocal agreement, the practitioner should bill the patient directly. • The practitioner should provide the patient with an itemized invoice and the patient may submit the claim to their home province's or territory's health insurance plan for reimbursement. • In order to be paid for providing medically required services to an individual who has coverage provided by the province of Quebec, the practitioner 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
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 practitioner 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, practitioner 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 practitioners 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 have chosen to opt out of the AHCIP.	• An individual may choose to declare to the Minister of Health they no longer wish to have coverage under the AHCIP and wish to be opted-out of the AHCIP. • The AHCIP cannot pay any claims submitted by practitioners for medically required services provided to an opted-out individual. • In such circumstances, the practitioner 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. • Additional Information found in Section 2.4 Patients who Opt Out of the AHCIP.
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 practitioners for medically required services provided to an individual who is a non-resident of Canada. • In such circumstances the practitioner 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.
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 practitioners 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

Individuals who are not eligible	How to bill
	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 practitioner 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 practitioners for medically required services provided to a Ukrainian with a valid and active PHN issued pursuant to the UETHBP. • Where an individual submits a PHN issued per UETHBP, it can be verified using the tools/methods described above. • More information on coverage can be found on the Alberta Health website at: https://www.alberta.ca/support-for-ukrainian-evacuees
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 practitioners for medically required services provided to Refugee Claimants and Failed Refugee Claimants.
WCB Patients	• Claims for medically required services provided by a practitioner 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. • For more information, see Section 4.5 Workers' Compensation Board (WCB) Claims.

2.4 Patients who Opt Out of the AHCIP

Alberta residents who opt out of the AHCIP are exempt from coverage. This means they are responsible for paying all health care costs they incur.

To opt out, residents must register or already be registered with the AHCIP and complete and return a Declaration of Election to Opt Out form - AHC0207 to Alberta Health. The opt-out period begins on the date the declaration is received in our office and remains in effect for three years.

Opted-out residents receive a Certificate of Exemption from the AHCIP, which they should present when obtaining health services. You may wish to keep a copy of this wallet-size card in the patient's record.

Alberta residents may choose to opt back in to the AHCIP before the end of their three-year opt-out period by completing a Revocation of Election to Opt Out form - AHC2127. The resident's AHCIP coverage is then reinstated 90 days after the opt-in request is received in our office. Reinstated residents receive a new Alberta personal health card, which they should present when obtaining health services. Dependants who complete a Revocation of Election to Opt Out form are exempt from the 90-day wait; coverage starts when the request is received.

Help is available for patients who are homeless and need assistance applying for AHCIP coverage through the AHS ID program.

If billing the patient directly, the practitioner has the ethical duty to consider the well-being of the patient and to provide care to a patient in an urgent situation regardless of their ability to pay.

2.5 The Interactive Voice Response (IVR) System

The Alberta Health IVR system enables practitioners and their staff to check a patient's PHN for validity and eligibility for coverage for a specific date. This service is available 24 hours a day, seven days a week; however, maintenance activities occur on Sundays at 10:45 a.m. for approximately two hours.

The IVR system is exclusively for the use of practitioners and their staff and is **not for general public use.**

The IVR system cannot be used to determine whether a patient is eligible for benefits that are subject to specific limits, such as podiatry and optometric visits. This type of confirmation can only be obtained by emailing the Health Insurance Programs Branch at Health.HCIPAProviderClaims@gov.ab.ca and arranging for a "limits" letter to be sent to the patient.

To use the IVR system:

1. Phone 780-422-6257 in Edmonton, or from outside Edmonton call toll-free 1-888-422-6257.
2. After the introductory message, you have 10 seconds to enter the patient's nine-digit PHN and press the # key.
3. At the prompt, enter the date of service for which you are checking the PHN.
   - For today's date, press #.
   - For a date prior to today's date, enter as YYYYMMDD, and then press #.
4. The IVR system will advise you:
   - If the PHN is eligible (i.e., in effect) on the date of service specified.
   - If the PHN is not eligible on the date of service specified.
   - If the PHN is invalid (i.e., not structurally correct).
5. After the IVR system has processed your first inquiry, it will prompt you to press # if you wish to check another patient's PHN. You can check as many PHNs as you need to during the same phone call.

2.6 Safeguarding Personal Health Cards and Numbers

It is important for all Albertans to protect their PHN and personal health card, and ensure they are used only when they are obtaining publicly funded health services.

The *Health Information Act* establishes the rules that must be followed for the collection, use, disclosure, and protection of health information.

Allied health practitioners, their staff and the public are encouraged to call the Alberta Health Tip-Line toll-free from anywhere in Alberta at 1-866-278-5104 if they have information about suspected or confirmed cases of abuse of Alberta PHNs or personal health cards.

In accordance with privacy legislation, any information reported on the Tip-Line is considered confidential. Tip-Line staff will not record any identifying information about the caller if they wish to remain anonymous.

3.0 Claim Submission

When preparing electronic claim submissions, it is essential to know your submitter's information reporting requirements and how to use their billing software to correctly create, change, delete and resubmit claims when necessary.

Particularly when using a new billing program, ensure the software vendor provides you with the support necessary to understand the processes for producing new and resubmitted claim transactions. This includes knowing how to send personal data, supporting text and supporting text cross-reference segments in cases when this information needs to be attached to base claim segments (Section 3.7 – Claim Segments.)

Offices that use paper-based methods to prepare claims for submission via an accredited submitter also need to ensure they understand the submitter's information reporting requirements for producing new claims and resubmitted claims. This is especially important when changing from one submitter to another, as reporting requirements can differ between submitters.

This section provides generic information about preparing a claim for submission. If you have questions about your submitter's particular claim preparation requirements or processes that cannot be answered by reviewing the information in this section, please contact your submitter for clarification.

The keys to trouble-free claim submissions are:

- Reporting data accurately and completely.
- Carefully checking the result code and explanatory code on your Statement of Assessment to understand the outcome of the original claim transaction if resubmitting a claim.
- Selecting the appropriate action code and claim number when you need to resubmit a claim.
- Knowing how to use your billing software or manual claim preparation process to generate your resubmission correctly.

Pursuant to the Alberta Health Care Insurance Act – Claims for Benefits Regulation 81/2006 – 4(3) – every practitioner who submits a claim for benefits for payment by the Minister is responsible for ensuring the accuracy of the information and is liable for inaccurate information shown on the claim for benefits.

3.1 Claim Basics

The following information is required on a claim to the AHCIP:

WHO was involved:

Enter:

- The personal health number of the patient (or, if applicable, their out-of-province registration number and province code).
- The practitioner identification number (PRAC ID) of the practitioner who provided the service.
- If applicable, the PRAC ID of the referring practitioner.

WHAT service was performed:

Enter the appropriate health service code (HSC) from the Schedule of Benefits Procedure List, plus any applicable modifier code(s) from the Price List.

WHERE it occurred:

Enter the facility number.

- If the facility is an office or non-hospital surgical facility, leave the Functional Centre field blank.

- If the facility is a general (active treatment) hospital, auxiliary hospital, or nursing home, you also need to enter a functional centre code.
- If the service was performed in a location that is not a registered facility, enter OTHR or HOME, as applicable.

WHEN it occurred:

Enter the date of service.

- If applicable, add the modifier for the time of day.
- For time-based services, enter the number of calls required to determine the units of time involved.

WHY the procedure was done:

From the Alberta Health Diagnostic Code Supplement (ICD9), enter the code(s) for the disease, condition or purpose related to the medical service you are claiming.

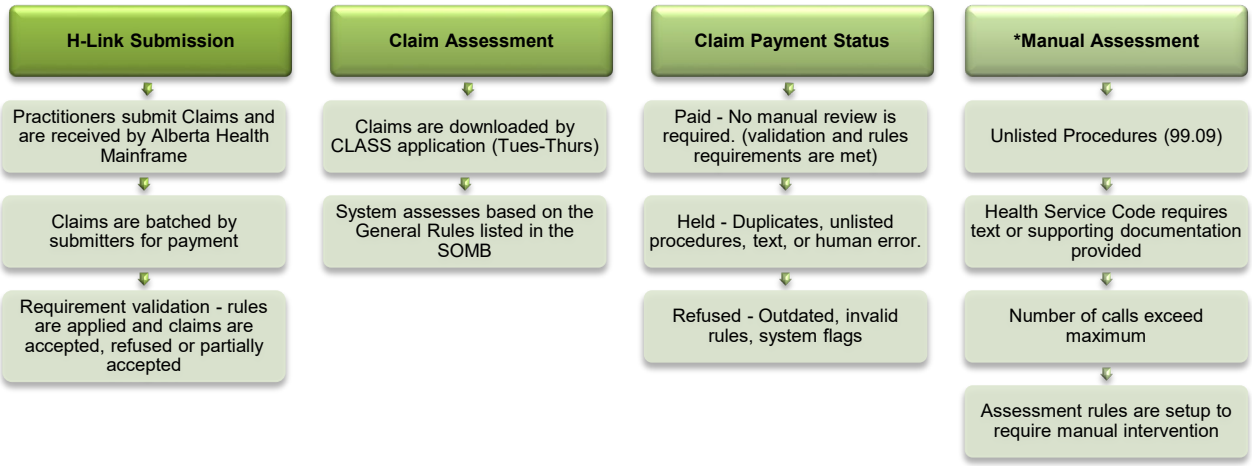
3.2 Claims Processing Overview

Section 4(2) of the AHCIA requires the Minister of Health to assess and approve all claims for benefits to determine if claims can be paid per the AHCIA. The determination of the level of review a claim will attract before it is assessed depends primarily on the Health Service Code used in the claim and the applicable rules of the Schedules of Benefits that relate to that HSC.

The Schedules of Benefits and individual HSCs have different requirements that must be met before a claim submitted using a particular HSC can be paid. It is important to note that claims that involve complex procedures may require a detailed review and more time-consuming manual assessment of the claim to determine if it is payable in accordance with the rules in the Schedule of Benefits.

In general, claims are submitted to Alberta Health using H-Link and pass through the automated claims processing system.

- Prior to assessment, the system checks and validates mandatory fields for accurate data.
- The claim is then assessed in accordance with the appropriate Schedule of Benefits and relevant general and assessment rules.
- The claim is then either paid in full, paid at a reduced rate, paid at zero, refused, or held.
- A held claim is assessed manually by a claims adjudicator.
- Once claims have been processed, Alberta Health prepares a Statement of Assessment and sends it to practitioners weekly by mail or electronically via their submitter. More information can be found under Section 5.1 Statement of Assessment.



3.3 Claim Processing Timelines

Under the *Claims for Benefits Regulation*, claims to the AHCIP are not payable if **received** by Alberta Health **more than 90 days** after the date the health service was provided, or the patient was discharged from the hospital.

If a claim is being resubmitted, it must be received within **90 days** from the date of the last Statement of Assessment on which the claim appeared.

A resubmitted claim is not payable if it is received by Alberta Health more than 90 days after the last transaction for that claim.

ONLY claims that will be received by Alberta Health outside 90 days of the date of service, BUT within 90 days of the last transaction date, require text. Text should quote all previous refused claim number(s), otherwise the claim(s) will be rejected. (See Section 3.4 - Outdated Claims)

Although Alberta Health offers to guide and facilitate the claims submission process, it is up to the health practitioner to manage their business as independent contractors. To help ensure they receive all payments they are entitled to for services provided, practitioners (and their staff) are expected to use sound business practices that support timely claim submission and reconciliation practices.

Pursuant to Section 7(1) in the *Claims for Benefits Regulation*, deadlines for claims submissions are firm unless satisfactory evidence of extenuating circumstances exists.

As per the *Claims for Benefits Regulation*, time is calculated from the time a practitioner provides the service (or patient is discharged from the hospital) to the time the claim was **received** by Alberta Health. Please note that the date on which you send your claims to your accredited submitter is not necessarily the date on which your submitter sends those claims to Alberta Health.

3.4 Outdated Claims

As per section 7(1) in the *Claims for Benefits Regulation*, unless evidence of extenuating circumstances satisfactory to the Minister of Health exists:

- A claim to the AHCIP is not payable if it is received at Alberta Health from a practitioner in Alberta more than 90 days after the date the health service was provided, or the patient was discharged from hospital.
- A resubmitted claim is not payable if received by Alberta Health more than 90 days after the last transaction for that claim.

Extenuating circumstances apply in very few cases. Examples of these extenuating circumstances include instances of disaster, fraud, theft of computer or paper records, where records were destroyed and were required to be recreated for submission. Lack of reconciliation, business management issues and vendor issues are not situations where the Ministry of Health has a basis to determine that extenuating circumstances arose, thus permitting application of section 7 of the *Claims for Benefits Regulation.*

Requests to consider extenuating circumstances in relation to outdated claims are reviewed on a case-by-case basis. If you wish to submit an outdated claim for which you believe extenuating circumstances apply, you must first contact Alberta Health at Health.HCIPAProviderClaims@gov.ab.ca. Alberta Health **may** provide the requester with the "Request for Submission of Outdated Claims form – AHC12836" if believed to be extenuating.

This form is required to be completed by allied health practitioners with details such as a description of the extenuating circumstance, the number of claims involved, the specific service dates, and dollar values. The request will be considered, and a written reply provided, including resubmission instructions, if applicable.

To avoid claims being outdated, Practitioners should ensure that they have a full understanding of the timelines and procedures for submitting claims used by their chosen billing vender.

Practitioners should also engage in timely reconciliation of their claims to allow their billing vendor ample time to submit claims. Please see General Bulletin 131.

3.5 Claims Payment Schedule

Under the *Alberta Health Care Insurance Act* (AHCIA) Alberta Health is responsible for ensuring that Alberta's health care system is accountable and provides assurance that claims for services provided and paid under the AHCIP are accurate and in accordance with the appropriate legislation. This is done by requiring all submitted claims to go through an assessment process as set out in the AHCIA. Section 4(2) of the AHCIA requires the Minister of Health to assess and approve all claims for benefits to determine if claims can be paid per the AHCIA.

Claims to the AHCIP are submitted electronically via H-Link. Claims **received** by Alberta Health are processed on Tuesdays, Wednesdays, and Thursdays of each week and the weekly cut-off is **Thursday at 4:30 pm**. When submitting within these time frames, the claims are processed for payment on Friday of the following week. Claims not received within this period are processed Tuesday the following week. Payments are made through direct deposit.

It is important to note that although most claims pass through the automated claims processing system, claims that involve complex procedures may require time consuming manual assessment. The determination of the level of review a claim will require before it is assessed depends primarily on the HSC used in the claim and the applicable rules of the Schedule of Benefits Procedure List that relate to that HSC. The manual assessment may involve a detailed review of the operative reports to determine the appropriate amount that can be paid in accordance with the Schedule of Benefits and the AHCIA.

Exceptions to the above payment schedule are:

- Good Friday – payment is delayed until the following Monday.
- Late December – payment is usually not made on the last Friday in December, as Alberta Health offices are closed for the holidays.

Practitioner offices and submitters are notified regarding exceptions to the payment schedule via Alberta Health Bulletins which are available on the Government of Alberta website, notifications on H-Link, or by inserts placed in the Statement of Assessment.

3.6 Action Codes

Every claim transaction must have an action code to indicate if it is a new claim or a resubmission of a previously processed claim. The four valid action codes are:

A (add) **C** (change) **R** (reassess) **D** (delete)

Action code	When to use
A (add):	To submit a claim for the first time or to resubmit a claim that was refused (result code RFSE) on the Statement of Assessment. (Section 5.4 – Result codes.) • Use a new claim number on all action code **A** claims. • A paid-at-zero claim is **not** the same as a refused claim. If you need to **resubmit a paid-at-zero claim**, use action code **R** (reassess) or **C** (change), as applicable.
C (change):	To change the information on a claim that appeared on the Statement of Assessment with result code APLY (applied) (Section 5.4 – Result Codes.) • Use the same claim number from your Statement of Assessment. • Include **all** the data from the original submission, but with the required changes. (Leaving a field blank will be recognized as a change.) • Any new supporting text segment will be added to any earlier text submitted for that claim. (Any supporting text cross-reference segment will be automatically connected to the referenced claims.) • **Do not** use action code **C** to change any of these details: – patient's personal health number – practitioners PRAC ID – business arrangement number To correct these details, you must **delete the incorrect claims** (see action code **D**) and **submit new**, correct claims (see action code **A**).

R (reassess): To resubmit a previously processed claim that was reduced in payment or paid at zero and you wish to have it reassessed with additional supporting information you are now providing.

- Use the same claim number from your Statement of Assessment.
- Include a supporting text segment with the additional information you wish to have considered. It will be added to any other earlier text on the claim. (Any supporting text cross-reference segment will be automatically connected to the referenced claims.)
- You do not need a base claim segment, as you are not changing any of the data. **You cannot change any of the data fields with action code R.**

D (delete): To delete a claim that was previously paid in full, reduced or paid at zero.

- Use the same claim number from the Statement of Assessment.
- You do not need a base claim segment or person data segment.
- You must **delete** the original claim if you want to change any of these details:
  - patient's personal health number
  - practitioners PRAC ID
  - business arrangement number
- Then submit a new claim (action code A) with the correct information and a new claim number.
- Pay-to-patient claims **cannot** be deleted.

3.7 Claim Segments

Each claim is made up of four basic segments:

- In-province provider base claim segment – CIB1
- Claim person data segment – CPD1
- Supporting text segment – CST1
- Supporting text cross reference segment – CTX1

Each claim segment is used for a different purpose, as described in sections 3.6.1 through 3.6.4. Carefully completing the data fields within the segments helps ensure claim payments are prompt and correct.

Alberta Health staff may not view your claims data in the same way that you view the data in your office. For example, your submitter may have set defaults for some data fields. Questions regarding your particular claim fields should be discussed with your submitter.

3.7.1 In-province provider base claim segment – CIB1

This segment provides the basic data needed to process claims submitted by Alberta practitioners and must be completed on every new claim. The data fields within this segment are:

Providers must ensure that their records are complete, accurate and support the services provided and benefits claimed. You must adhere to your respective college standards of practice with regards to documentation at all times. Please refer to Section 5.9 Monitoring and Compliance for more information.

Claim Type:

Enter **RGLR** for all action code **A** (add) or **C** (change) claims.

- Leave this field blank for action code **R** (reassess) and **D** (delete) claims.

PRAC ID:

Enter the practitioner identifier number (PRAC ID) of the practitioner who provided the service.

- Do not enter a professional corporation identifier number in this field or the claim will be refused.
- It is **not** appropriate to claim your services under another practitioner's PRAC ID. Only the PRAC ID of the practitioner who provided the specific service is acceptable on the claim for that service.

Skill Code:

Practitioners who submit claims to the AHCIP have a skill code that identifies their discipline. Some practitioners have more than one skill code, for example, dentists and optometrists can have more than one skill if they have recognized specialities or certifications.

- If you have only one skill code, you do not have to enter it on the claim. The processing system will automatically default to the correct skill code.
- If you have more than one skill and have designated one of them as your primary skill on your business arrangement (e.g., general practice dentistry primary skill, oral surgeon other skill), you could leave this field blank if you performed the service using your primary skill.
- If you have more than one skill and you have not designated a default skill, enter the skill code that is most appropriate for the service being provided.

Service Recipient PHN:

Enter the patient's nine-digit personal health number from their Alberta personal health card.

- If the claim is for a newborn whose PHN is unknown leave this field blank and provide information in the person data segment of the claim. (Section 3.7.2 - Claim Person Data Segment – CPD1.)
- Once the PHN appears on the Statement of Assessment, enter it on any subsequent claims.

Health Service Code (HSC):

Enter the appropriate code from the Procedure List in the Schedule of Benefits.

- **Reminder to dentist and podiatrists:** Procedures claimed under section 99.09 (Procedures not elsewhere classified) require supporting text/documentation. (Section 3.11 - Submitting Claims for Unlisted Procedures.)
- It is **not** appropriate to submit a claim using a code from the 99.09 section when a specific HSC for the service provided is listed elsewhere in the Procedure List.
- When an unlisted service is provided, it is **not** appropriate to submit a claim using an established HSC that is similar to the actual procedure performed.

Service Start Date: Use YYYYMMDD format to enter the date on which the service was performed.

- For hospital visits, enter the date of the **first** day of consecutive hospital visit days. In the Calls field, enter the number of consecutive days of visits, to a maximum of 99 days.

  For a patient in hospital longer than 99 days, start a new claim for the additional days, beginning at call one (1). Enter the original admission date in the Hospital Admission Date field.
- Except for hospital in-patient services, claims may not be submitted more than 90 days from the date of service.

Encounter Number: This field defines the number of **separate** times the practitioner saw the same patient on the same day either for a different condition, or for a condition that has worsened.

- Most often, the encounter number entered is one (1). An additional separate encounter would be encounter 2 on a separate claim.
- "Encounter number" and "calls" **do not mean the same thing.** Do not use encounter numbers to denote the number of services (calls) you are claiming for a HSC.

Diagnostic Code: Diagnostic codes are dependent on HSC, Category Codes and Notes as indicated in the Schedule of Benefits.
Unless noted otherwise in the Schedule of Benefits, diagnostic codes are not required for:

- Anesthetic services
- Surgical assist services
- Laboratory and pathology services (E-prefixed HSC)
- Diagnostic radiology services (X-prefixed HSC).

Using the Alberta Health Diagnostic Code Supplement (ICD9), select the most precise diagnostic code for the service being performed. A four-digit code is preferred as it is more specific than a three-digit heading code.

- Enter the primary diagnosis in the first Diagnostic Code field. Two additional fields are available for secondary diagnoses, if needed. They can be used to denote the overall diagnosis or separate health concerns.
- Claims received with diagnostic codes that are not appropriate for the health service code submitted will be refused.

Diagnostic codes are required for podiatrists, dentists, and where applicable, optometrists.

Calls: **Applies to dentists and podiatrists**. Enter up to three digits to identify the number of calls for the HSC you are claiming, or the number of units for time-based services you provided.

- Where applicable, the Price List in the Schedule of Benefits identifies the maximum calls allowed for each HSC, or the number of units for time-based services.
- If the number of services you provided exceeds the maximum specified for that HSC, submit your claim with the actual number of calls plus supporting text or documentation for the claim to be considered for payment. Claims without this information will be automatically reduced to the maximum calls specified in the Price List.
- Hospital visits are restricted to **two digits**, i.e., to a maximum of 99 calls per claim. (See Service Start Date field.)

Explicit Fee Modifier: Modifiers are used in conjunction with the health service code to determine the amount payable. (Section 3.9 - Modifier Codes.)

- Enter any applicable explicit modifier(s) in this field.

Facility Number: Enter the facility number that identifies where the service was performed (e.g., practitioner's office, hospital, etc.).

- Leave blank if the service was performed in a location that is not a registered facility. (See Location Code field.)

Functional Centre: Complete this field only if the service was performed at a registered facility that has functional centre codes. Example: the neonatal intensive care unit within a hospital is a functional centre.

- To avoid claim refusal, be sure to use the appropriate functional centre code. Refer to the Facility Listing for detailed information about facility numbers and functional centre codes for Alberta's publicly funded facilities.

Location Code: If the service was performed in a location that is not a registered facility, enter either HOME (for the patient's home) or OTHR (other), as applicable.

Business Arrangement: Enter the business arrangement number under which the practitioner is making the claim. (Section 1.0 - AHCIP Basics for the Practitioner.)

Pay-to Code: Enter the applicable code to identify the person or organization that is to receive the claim payment:

BAPY (Business arrangement payee) – Used most often, this code is used to pay the practitioner, clinic or professional corporation as defined in the business arrangement.

CONT (Contract holder) – Pay the AHCIP registrant (head of the family).

RECP (Service recipient) – Pay the patient.

PRVD (Service provider) – Pay the practitioner. This code is not often used; BAPY is used for direct provider payment.

OTHR (Other) – Someone other than the above. (See Pay-to PHN field.)

- A patient under age 14 cannot be the payee. If you want the patient's parent to be paid, enter CONT. For a guardian or other responsible party to be paid, enter OTHR. (See Pay-to-PHN field.)

Pay-to PHN: If you enter OTHR in the Pay-to Code field and you know the other person's personal health number, enter it here.

- If you do not know the PHN, fill out a person data segment for the payee.

Referral PRAC ID: If the service was provided because of a referral, enter the referring provider's PRAC ID.
Do not enter a professional corporation identifier number in this field or the claim will be refused.

Out-of-Province Referral Indicator: This field is required **only** for Alberta patients who are referred by an out-of-province practitioner.

- Enter Y if a provider outside Alberta referred the patient for the service. Complete a person data segment for the out-of-province provider.

Chart Number: This field is reserved for practitioner use. You can enter up to 14 alpha or numeric characters as a source reference or other type of file identifier.

Claimed Amount: If the claim is "by assessment" or for an unlisted procedure, enter the fee requested. You also need to provide supporting text or documentation. (Section 3.11 - Submitting Claims for Unlisted Procedures.)

- Claimed amount is not required for other health service codes unless you are requesting a lower fee than what is listed in the Schedule.

Claimed Amount Indicator:

Enter Y in this field **only** if the fee you are claiming is **less** than the amount normally paid for this service.

Intercept Reason:

This field is currently not used.

Good Faith Indicator:

Enter Y if submitting under the good faith policy. (Section 4.1 – Billing for Patients who are Unable to Provide a Valid Personal Health Card.)

- You must complete a person data segment for the patient.

Newborn Code:

If the patient is a newborn whose PHN is unknown, enter the applicable code:

LVBR (live birth)
MULT (multiple birth)
STBN (stillborn)
ADOP (adoption)

- You must also complete a person data segment for the newborn.
- Once you know the newborn's PHN, you can enter it in the Service Recipient PHN field on any future claims. You will not need a newborn code or a person data segment.

Paper Supporting Document Indicator:

Enter Y if supporting documentation will be sent separately.

- Send supporting documentation on paper only if it contains diagrams or an operative report and if including a text segment on the claim would be insufficient.
- Send the supporting documentation at the same time the claim is submitted. Be sure it makes reference to the applicable claim number.
- Alberta Health reserves the right to request supporting documents at any time. Providers must ensure that their records are complete, accurate and support the services provided and benefits claimed.

Hospital Admission Date:

Applies to dentists and podiatrists. This field is used when claiming for hospital visits.

- Enter the date of admission here. Also enter the number of consecutive hospital visit days in the Calls field. (See Service Start Date and Calls fields for information about patients in hospital longer than 99 days.)
- Non-consecutive hospital visit days also require a hospital admission date for each non-consecutive visit. Create a separate claim after each interruption in consecutive hospital days.
- If you are taking over hospital care from another dentist/podiatrist (see the general rules in your Schedule of Benefits) and claiming for your services, enter the date of the patient's hospital admission in this field.

Practitioners must ensure that their records are complete, accurate and support the services provided and benefits claimed. You must adhere to your respective college standards of practice with regards to documentation at all times as referred to by the *Alberta Healthcare Insurance Act* and *Claims for Benefits Regulation*. Please refer to Section 3.0 Claim Submission for more information.

3.7.2 Claim person data segment – CPD1

This segment must be completed for:

- A patient (RECP) who does not have a PHN or does not know their PHN (i.e., Section 4.1 – Billing for Patients who are Unable to Provide a Valid Personal Health Card.)
- A newborn patient without a PHN. (Section 4.2 - Newborn claims – Alberta Residents.)
- An "other" payee (OTHR); i.e., when someone other than the patient or AHCIP registrant (head of the family) has paid the claim and now wants to be reimbursed.

The following tips will help you correctly complete a person data segment:

- Be sure to spell the patient's hometown or city correctly and without punctuation, or the claim will be refused.
- Spaces are not required in the postal code field.

3.7.3 Claim supporting text segment – CST1

Use this segment only if the claim you are sending requires supporting text. When required, this segment is sent at the same time the base claim segment is submitted.

If several claim transactions for separate procedures, for the same patient, on the same date of service are required, please ensure the supporting text is applicable to the HSC of the individual health service being submitted. Each HSC will require its own specific information.

You may want to check with your accredited submitter regarding the data requirements of the claim supporting text segment as including text on claims transactions where it is not required will delay the processing of claims.

3.7.4 Supporting text cross reference segment – CTX1

This segment applies when the same supporting text is used for more than one claim. Up to 14 other claims can be cross-referenced to one claim that contains the relevant supporting text. Check with your submitter regarding the data requirements of this segment.

3.8 Mandatory Claim Fields and Segments

Here are the **four situations** when you **must** complete specific fields or segments on the claim.

If the claim involves	then you must complete this field/segment
• a first-time claim for a newborn:	✔ newborn code ✔ person data segment (including parent/guardian PHN)
• good faith	✔ good faith indicator (enter Y) ✔ person data segment
• pay-to code OTHR:	✔ pay-to PHN field **or** person data segment
• out-of-province referral:	✔ out-of-province referral indicator ✔ person data segment

3.9 Modifier Codes

Modifier codes influence the payment of claims. They can add or subtract an amount from the base rate of a HSC, multiply the base rate by a percentage, or replace it with a different amount.

All current modifier codes and their explanations are listed in the Modifier Definitions section in the Schedule of Benefits. The Price List section in the Schedule lists the specific modifiers that apply to each HSC.

Modifier codes are either explicit or implicit, as described below:

Explicit modifiers: When applicable, the practitioner or their billing staff must enter these on the claim. They indicate when certain situations or circumstances affect the provision of the service. Two explicit modifier examples are:

1. **Role** – Identifies the practitioner's function at the time service was provided, e.g., surgical assistant.(When a claim for a surgical procedure is submitted without a role modifier, it is assumed to be the claim from the surgeon.)
2. **Lesser value procedure** – Identifies that this procedure should be processed at a reduced rate.

Implicit modifiers: When applicable, these are added automatically to a claim by the AHCIP processing system. They are derived from information on the claim when it is received at Alberta Health. The practitioner or their staff **must not** enter implicit modifiers on claims. Two implicit modifier examples are:

1. **Number of Services** – Derived from data in the Calls field.
2. **Skill** – When the Skill Code field is left blank, the claim is automatically processed using the default skill indicated on your business arrangement with Alberta Health.

3.10 Claims Reject Due to Patient Eligibility

If your claim is refused because of a problem with the PHN, you have a number of options available to you:

- Confirm that the PHN on your claim is correct (check for a clerical error). If applicable, submit a new claim with the correct PHN.
- Contact the patient to confirm the status of their health coverage. If you obtain a correct PHN, submit a new claim.
- Verify the patient's eligibility using Alberta Netcare. For more information visit www.albertanetcare.ca.
- If you cannot obtain a correct PHN, please refer to Netcare for information on the patients PHN. (Section 2.2 – Confirming Patient Eligibility for AHCIP Coverage.)

A current Alberta address by itself does not mean a resident is covered by the AHCIP. Residents who have moved to Alberta may be covered by their previous home province/territory plan for up to three months. Practitioners **must** ask new patients if they have recently moved to Alberta and if the patient has made application for coverage to the AHCIP.

3.11 Submitting Claims for Unlisted Procedures

The 99.09 section of the SOMB contains the HSC (99.09A to 99.09Z) for unlisted procedures. When you provide a service, either as a single item or a combination of items, that is not listed in the Schedule, you may be able to use the applicable unlisted procedures code on a claim submission.

If the unlisted procedure is not insured by the AHCIP, you will need to bill the patient for the service.

Prior to submitting a claim, you must:

1. Determine if the service is insured under the AHCIP. If the service is uninsured, experimental or outside the standard of care practices in Alberta, do not submit a claim transaction to Alberta Health.
2. Review the Schedule to determine if an HSC exists for the service – it may be listed in an unfamiliar section, or it may be a combination of services. If you locate a specific HSC for the service, submit the claim accordingly.
3. If you cannot identify an appropriate HSC, submit your claim using the appropriate code (99.09A to 99.09V) from the unlisted procedures section of the SOMB.

The following process must be followed when submitting a claim for an unlisted procedure:

1. Complete the 99.09 Claim Summary form, available online with the following key information:
    a. The equivalent or comparable service listed in the SOMB, in terms of time, complexity and intensity.
    b. Provide rationale to support payment of the claim.
        i. Is the service considered a standard of care or is it experimental?
        ii. Is this service insured in a medical schedule in any other province?
        iii. May this service be incorporated into the clinical practice or is this a one-off service?
2. Attach supporting information, such as an operative report and include the service description, time required, and the amount being requested.
3. Send completed forms and supporting information to the Claims Management Unit via Fax to 780-422-3552 or e-mail to Health.HCIPAProviderClaims@gov.ab.ca.

Practitioners **must** submit a completed 99.09 Claim Summary form along with the required supporting information as stated above. Alberta Health will keep the submitted claim in a HELD status for 90 days from the date of the submission. Failure to submit the completed form and supporting information within 90 days will result in claim being refused for more information.

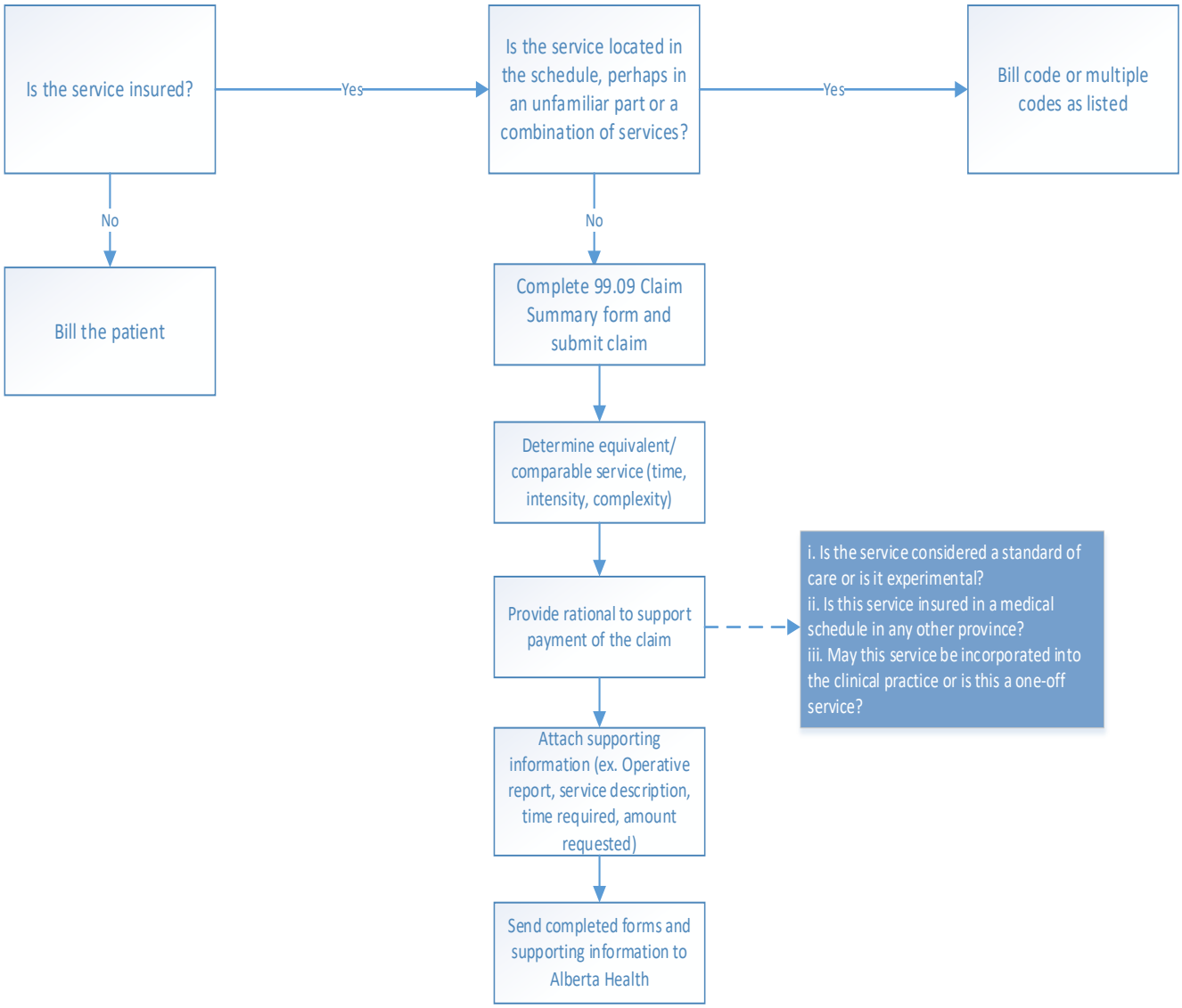
All information requirements must be satisfied in order for the application to be considered. Submissions that lack the required information will be denied and require complete resubmission as Alberta Health will not retain incomplete applications.

Alberta Health will assess the claim for the unlisted procedure by comparing the service provided and the fee claimed with similar or comparable services listed in the SOMB. The assessment will be based on information concerning the time, complexity, and intensity of the service, as provided in the claim, the 99.09 Claim Summary form and supporting information.

It is important to note that the SOMB does not permit procedures performed at the same encounter that are considered insurable but paid at an amount inclusive in other procedures performed. This means that the total benefits paid under the 99.09 process for a patient encounter should not be submitted under another HSC.

Additionally, to complete an evaluation of an insurable service billed by practitioners as a 99.09 HSC, the practitioners claim history is reviewed by Alberta Health to identify if other claims were submitted for the same procedure to ensure that the insured procedure claimed under the 99.09 HSC was not included in a claim that was previously paid or a duplicate of a previously paid claim. If it is found that a previously billed and paid HSC is included in the 99.09 billing, then the paid claim will be reversed and paid as part of the assessment amount under the 99.09 claim.

3.11.1 Claims for unlisted procedures submission guide



3.11.2 Additional compensation requests

Additional Compensation claims are services listed in the Schedule of Benefits for but may require additional compensation due to additional effort required because of the time, intensity, and complexity of the services.

Benefits may be claimed in excess of those listed in the Schedule of Benefits for services involving unusual complications or care. Due to unusual complications of care and requests for increased compensation, additional documentation, either an operative report or other detailed description of the care is required to support the claim prior to submission.

To submit a claim for additional compensation:

1. First, consider if the claim is reasonable: Did the procedure have unusual complications that contributed to the increased level of time or intensity? Did the procedure require significantly more time than the average for this procedure?

2. Consider how much additional compensation you will request.

3. Prepare a letter that summarizes your request and rationale as to why this claim should be considered for additional compensation.

4. Locate the operative report and prepare for faxing.

5. Enter the claim information as usual using the HSC and patient demographic information. You will also enter text on the claim that states you are requesting additional compensation for the claim and state the amount you are requesting.

6. Once you have submitted the claim your software will provide you with a claim number. Record the claim number on the top right-hand corner of the letter and all pages of the operative report.

7. Send completed forms and supporting information to the Claims Management Unit via fax 780-422-3552 or email Health.HCIPAProviderClaims@gov.ab.ca.

8. The claim will appear on the next Statement of Assessment from Alberta Health as paid at the listed rate. These claims are processed manually so there is a lag-time between submission and payment of the additional compensation. Additional compensation may be paid after an internal Committee reviews your claim.

   You will be informed of the decision made by the Committee indicated on the Additional Compensation Claim Summary form, which will be sent back to you through email, mail or fax.

   As a note, not all claims that are submitted for additional compensation are paid as requested.

The Additional Compensation Claim Summary form, is available on the Alberta Health at https://www.alberta.ca/health-professional-business-forms.

4.0 Special Situations

4.1 Billing for Patients Who Are Unable to Provide a Valid Personal Health Card

Claims for benefits for medically required services can be submitted for patients who are unable to provide a valid Alberta personal health care card/number or who do not have active AHCIP coverage (commonly referred to as a "good faith" claim).

This policy minimizes the risk of Alberta practitioners not being paid for services provided to Alberta residents who the practitioner believes are eligible for coverage under the AHCIP at the time of service but cannot provide proof of coverage.

Prior to submitting a claim to Alberta Health for payment, for patients that claim to be registered with the AHCIP but are unable to provide proof of coverage or residency, the practitioner, either personally or through their staff, should exhaust all options outlined in Section 2.2 – Confirming Patient Eligible for AHCIP Coverage to verify that a patient has valid and active coverage.

4.1.1 Submitting a claim

If a practitioner believes a patient is eligible for coverage under AHCIP at the time of service but cannot provide proof of coverage, a claim for benefits can be submitted to the AHCIP for payment.

On your claim complete the following with the identified information:

1. CIB1 – Claim data segment which must contain:
   - Prac ID, HSC, Date of Service, Diagnostic Codes, 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 such as 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. Adding text to claims will delay the assessment and payment of the claim.

4.2 Newborn Claims – Alberta Residents

The first time you submit a claim for a newborn, the following data must be entered on the claim so the newborn can be registered, and the claim processed.

Base claim segment:

- Newborn code – enter the applicable code from the following choices:

  LVBR (live birth)
  ADOP (adoption)
  MULTI (multiple births)
  STBN (stillborn)

Person Data segment:

- Person type (RECP – service recipient)
- Surname
- First name (if known)
- Middle name (if known)
- Birthdate (YYYYMMDD)
- Gender (M or F)
- Mother's/Guardian's PHN
- Address

- Do not use dashes, abbreviations or punctuation, or the claim will be refused. (e.g. 2014 Brookview Crescent Regina SK S3S 4R5)

Do not enter the mother's PHN in the Service Recipient field on the base claim segment. In the case of multiple births when the first names are not known, provide information such as Twin A, Twin B, etc., in the claim supporting text segment that accompanies the claim.

When you receive payment for the initial claim, the newborn's PHN will be indicated on the Statement of Assessment. You will use that PHN for future claims and will not need to complete the Newborn Code field or the person data segment again.

4.3 Virtual Health Claims

Virtual health care is an insured service under the AHCIP, when delivered in the province of Alberta by a licensed Alberta practitioner to eligible Albertans with valid AHCIP coverage. HSC for insured virtual health services are listed in the Schedule of Benefits. Inquiries regarding HSC and rules for virtual care can be sent to health-pcsp.admin@gov.ab.ca.

Practitioners providing health services virtually must ensure they have a physical clinic within reasonable travel proximity of the patient to fulfil the need for in-person care when appropriate as required or requested by the patient.

4.4 Third-Party Service Requests

Patient examinations performed at the request of a third party for their exclusive use are not insured services under the AHCIP. Payments for these types of services are the responsibility of the third party or the patient. Please refer to the general rules of your applicable Schedule of Benefits.

4.5 Workers' Compensation Board (WCB) Claims

Claims for Alberta residents who are injured at work **must be** submitted directly to the Workers' Compensation Board (WCB) – Alberta. If the WCB denies the claim and the service is insured under the AHCIP, you may submit to Alberta Health a claim with text indicating the date of the WCB letter informing you that the claim was denied. The claim must be submitted **within 90 days** of the date of the WCB refusal letter. **A copy of the letter indicating the patients Personal Health Number and the WCB online remittance must accompany the claim** and can be faxed to 780-422-1958.

The WCB online remittance is available by logging into myWCB at https://my.wcb.ab.ca/ess/signin.
For information on how to sign in, or to setup a login, visit https://www.wcb.ab.ca/resources/for-health-care-and-service-providers/online-services.html. Practitioners can also contact the WCB eBusiness Support Team at 780-498-7688 or the WCB Claims Contact Centre toll-free at 1-866-922-9221.

For information on WCB, please visit https://www.wcb.ab.ca/

> If a claim is submitted without a copy of the letter and/or the WCB online remittance, Alberta Health will refuse the claim with Explanatory Code 21AC (Workers' Compensation Board Supporting Documentation required).

Practitioners are responsible for ensuring that services which are the responsibility of the WCB are not submitted to Alberta Health. If a claim is submitted to Alberta Health in error, practitioners should submit a "delete" claim (action code D) to reverse the claim. For assistance in submitting a "delete" claim, please refer to Section 3.6 – Action Codes.

> Alberta Health regularly reviews practitioner claims to identify and recover funds where a practitioner received payment for treatment of a patient's work-related injury/condition from both Alberta Health and the WCB, and where a practitioner submitted claims to and received payment from Alberta Health for services that should have been submitted to the WCB.
>
> Where applicable, adjustments will be made monthly to recover Alberta Health payments for services that are the responsibility of the WCB. These adjustments appear on the Statement of Assessment with Explanatory Code 21 (Workers' Compensation Board Claim).

If you are treating a patient for an **unrelated** medical condition and providing a WCB-related service at the same encounter, you may submit a claim to Alberta Health under health service code 03.01J.

A non-resident of Alberta who is working in Alberta and who is injured at work may claim WCB benefits from either the workers' compensation organization of the province where they were injured or the province where they reside. You will need to check with your patient regarding the province from which they will be claiming WCB benefits. Once this information is confirmed, your office can submit a claim directly to the appropriate provincial workers' compensation organization.

> Do not submit WCB claims to Alberta Health as "good faith claims". Claims for work related injuries to an Alberta resident must be submitted directly to WCB for payment.

4.6 RCMP Member Claims

Members of the Royal Canadian Mounted Police (RCMP) who are residents of Alberta are eligible for coverage under the AHCIP.

Alberta RCMP members have been issued Alberta Personal Health Cards and are expected to show their Personal Health Card along with photo identification when visiting a doctor's office or hospital in Alberta and receiving services insured under the AHCIP.

Claims for insured services provided to RCMP members registered with the AHCIP are to be submitted to the AHCIP. Payment will be made in accordance with the general rules and assessment criteria associated with Alberta's schedules of benefits. The claim submission deadline will be the same as for services provided to other Albertans.

Claims for services provided to RCMP members for work-related injury/illness should be directed to the RCMP and **not** to the WCB or Alberta Health. The current process pertaining to completion of "Medical Certificate – Form 2135" remains in effect.

4.7 Health Care Services Provided to Albertans Elsewhere in Canada

Allied health services are not covered under the AHCIP outside Alberta. These services include:

- vision care
- podiatry and optometry services
- dentistry services except for medically required oral surgery

Alberta residents receiving allied health services outside Alberta are responsible for the costs.

4.8 Health Care Services Received by Albertans Outside Canada

All Albertans have the option of obtaining medical treatment outside Canada if they believe it best suits their needs. However, when exercising this option, they need to be aware that the AHCIP provides limited coverage for out-of-country health services.

Health services received by Albertans outside of Canada that are provided by health care providers other than physicians are not covered.

Alberta Health provides two sources of funding for Albertans requiring medically necessary health services outside Canada: application to the Out-of-Country Health Services Committee (OOCHSC) and partial coverage under the AHCIP.

4.8.1 Application to the Out of Country Health Services Committee (OOCHSC)

The OOCHSC reviews applications for funding of insured practitioner and hospital services received outside of Canada when those services are not available in Canada and when all other appropriate health service options in Canada have been fully exhausted.

Funding applications to the OOCHSC must be submitted by a patient's attending Alberta practitioner or dentist and meet eligibility criteria.

Eligibility

Prior approval is required for all elective (non-emergency) medical services.

Under provincial legislation, patients may not self-refer or submit documentation to the OOCHSC.

Responsibility for treatment remains with the referring Alberta practitioner or dentist.

Applications must meet all of the following requirements as set out in the *Out-of-Country Health Services Regulation*:

- The resident has valid health insurance coverage under the AHCIP;
- The resident has endeavored to receive the services in Canada, the services are not available in Canada and all other appropriate options in Canada have been exhausted;
- The services must be medically necessary and supported by clinical documentation from the applying Alberta practitioner or dentist;
- The services must be medical, oral surgical, or hospital services insured under the AHCIP or the Hospitalization Benefits Regulation;
- The services will be provided in a manner that accords with accepted standards of practice in Alberta; and
- The services are not part of a research study or clinical trial and are not experimental.

Applications can be submitted by mail to:

Chair, Out-of-Country Health Services Committee
PO Box 1360 Station Main
Edmonton, AB, T5J 2N3

Or by e-mail to health.oochsc@gov.ab.ca.

For more information about the OOCHSC application process or to download an application form, please visit https://www.alberta.ca/ahcip-out-of-country-health-funding.

Submitting a request for funding to the OOCHSC **does not guarantee approval**. When making decisions, the OOCHSC is required to follow the criteria as set out in the *Out-of-Country Health Services Regulation*, which can be found online at https://open.alberta.ca/publications/2006_078.

Appeals

Funding applications that have been denied by the OOCHSC can be appealed to the Out-of-Country Health Services Appeal Panel which operates separately from the OOCHSC. Appeals may be submitted by the Alberta practitioners who submitted the application for the Alberta resident, or by the Alberta resident. After review, the Appeal Panel may confirm or vary the OOCHSC decision, or it may substitute its decision for the OOCHSC decision.

A written notice of appeal must be received by the Appeal Panel within 60 business days of receiving the Committee's decision.

Information about the Appeal Panel is available by calling 780-638-3899 in Edmonton, or toll-free by dialling 310-0000, then 780-638-3899 when prompted.

Appeals can be submitted in writing to:

Chair, Out-of-Country Health Services Appeal Panel
PO Box 1360 Station Main
Edmonton, AB, T5J 2N3
Fax: 780-644-1445

4.8.2 Partial AHCIP coverage

Physician and/or hospital services received outside of Canada are only eligible for reimbursement under the AHCIP if they are provided on an emergency basis. The Alberta Health Care Insurance Regulation and the Hospitalization Benefits Regulation define emergency services as insured services being provided in relation to an illness, disease or condition that is acute and unexpected, arose outside Canada, and requires treatment, without delay, outside Canada.

- Eligible insured physician services received outside Canada are paid at the lesser of the amount claimed, or the rate an Alberta physician would be paid for that service or the most similar service.
- The rate for eligible inpatient hospital services is $100 per day, not including the day of discharge.
- The rate for eligible outpatient services is $50 per day, with a limit of one visit daily.

The hospital services rates are the maximum that is reimbursed for all services provided to a patient, such as room and board, nursing, laboratory and X-ray services, medical supplies, and prescription drugs. Insured hospital services must be provided in a general or auxiliary hospital; services provided in a private health facility are not eligible for reimbursement under provincial legislation.

In addition, the AHCIP does not cover food, lodging, transportation, or other costs related to obtaining health services outside Canada.

Further information regarding coverage outside Canada is available on the Government of Alberta website at: https://www.alberta.ca/ahcip-coverage-outside-canada.aspx.

Further information on how an Albertan can submit a claim for reimbursement is available online at: https://www.alberta.ca/ahcip-submit-claim.aspx.

4.9 Out-of-Province Patients

Patients receiving insured allied services covered under AHCIP, such as oral maxillofacial surgery are still required to present a valid provincial/territorial health card. Practitioners are required to validate coverage. Where coverage is not available, patients are responsible for the cost of services provided and are billed directly.

4.9.1 Practitioner billing

There are two ways an Alberta allied health practitioner can bill for patients who are from outside Alberta:

1. For patients from Quebec practitioners should charge patients with active Quebec coverage directly for services performed in Alberta and have the patient complete a Quebec Claim for Physician/Practitioner Services form and submit it directly to the Province of Quebec's provincial health insurance plan – Régie de l'assurance maladie du Québec (RAMQ)
2. For patients from other Provinces/Territories, bill the patient directly and provide them with an itemized invoice. The patient may submit the claim to their home province health plan for reimbursement.

> If billing the patient directly, the allied health practitioner has the ethical duty to consider the well-being of the patient and to provide care to a patient in an urgent situation regardless of their ability to pay.

4.9.2 Out-of-province patient eligibility

Patients who are temporarily absent from their province/territory of residence **must provide a valid provincial/territorial health card** when accessing insured health care services in Alberta. Where the province/territory includes an expiry date on the health card, the card must be valid on the date(s) that the services were provided.

> Quoting a number without presenting a card is not acceptable. **Practitioner offices must see the patient's current card and information on each visit.** Using the patient's information already on file is not acceptable. Alberta Health will no longer provide practitioner offices, hospital/clinics with patient's out-of-province health care numbers. Refer to Section 2.2 - Confirming Patient Eligible for AHCIP Coverage for billing options if a valid health insurance card is not presented.

Samples of all province/territory health cards are displayed in Appendix B – Valid Provincial/Territorial Health Cards. If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office (Appendix C – Provincial/Territorial Health Plan Contact Information) to resolve any beneficiary entitlement concerns.

5.0 Reviewing & Reconciling Claim Results

Although Alberta Health offers to guide and facilitate the claims submission process, allied health practitioners are responsible for the submission and reconciliation of their claims. Alberta Health provides practitioners with original Statements of Assessments and Accounts as claims are adjudicated and paid weekly. Practitioners should reconcile their claims regularly by reviewing their Statements and consulting the Schedule of Benefits.

5.1 Statement of Assessment

Once claims have been processed, Alberta Health prepares a Statement of Assessment and sends it to practitioners weekly by mail or electronically via their submitter. As necessary, explanatory codes displayed on the statement will help identify changes, problems, or delays regarding specific claims. These statements are valuable documents to help practitioners keep track of their assessed claims.

If you already receive a Statement of Assessment directly from your submitter and do not wish to receive the Alberta Health paper version, complete the Business Arrangement and Relationship form - AHC11236 to have them suppressed. Only the Statement of Assessments can be suppressed; all other statements will be mailed out.

Note: Once Statements of Assessment have been suppressed, they cannot be reprinted, and you can no longer receive them for that time period

The information provided in a Statement of Assessment is in the following sequence:

- Business arrangement number.
- Service provider (in numerical order according to PRAC ID).
- Patient (in numerical order according to PHN).
- Most current date of service (DOS) for each patient when multiple claims are processed.

The Statements are numbered sequentially each time a statement is produced. This number will prove useful when you are reconciling accounts.

Regularly, reconcile each Statement of Assessment with your claim submission records.

- Make sure that all your submitted claims have been processed by the AHCIP. **Much of this can be done with the computer output details supplied by your submitter.**
- Always allow for the AHCIP items that are still in process, i.e., those claims that have been received by the AHCIP but not fully assessed. Each of these claims plus any applicable explanatory code(s) will appear on a future statement after assessment is complete.
- It is your responsibility to retain all Statements of Assessment until you have completed your reconciliations, no longer require them for tax purposes and have met the requirements in Section 15(2) of the Alberta Health Care Insurance Regulation which states that **billing information must be kept for six years**.

Alberta Health **does not** issue T4 Slips for tax purposes.

- A Statement of Assessment that reports the results of your pay-to-patient claims is **not** a statement showing claim payments to **you** or deductions from **you**. This type of statement advises you about changes to claims due to patient eligibility.

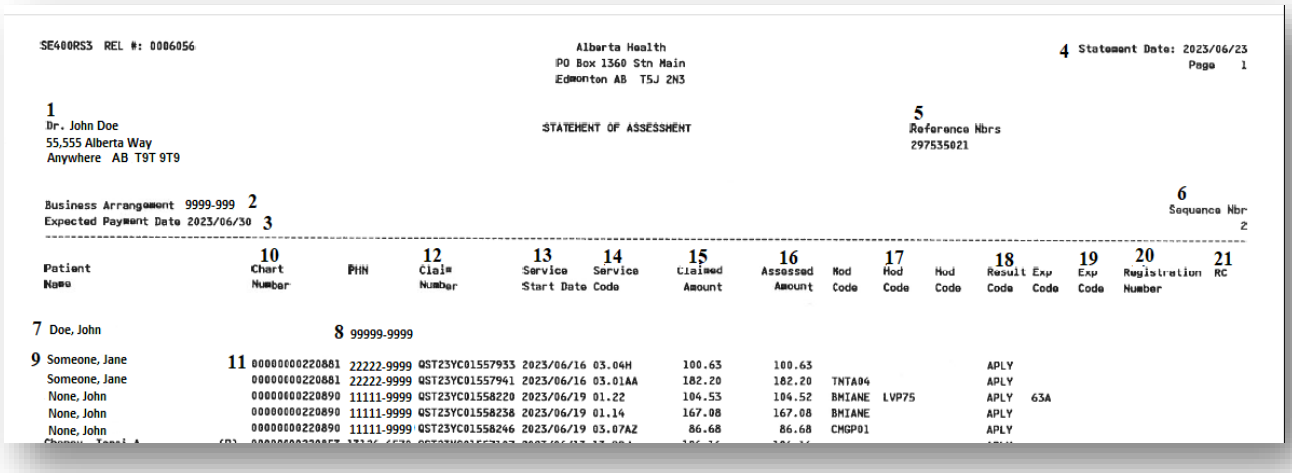
If you are missing any Statement of Assessments within 30 weeks of the issue date, please contact your submitter for electronic assessment result details files. This file contains the same assessment results of each claim submission that appears on the Statement of Assessment. If you are your own submitter and require Statements within 30 weeks of the issue date, contact the H-Link Help Desk at 780-644-7643 (toll-free 310-0000, then 780-644-7643).

If you require copies of the Statement of Assessment outside 30 weeks of the issue date you must complete and submit the "Request for Statement of Assessment/Account" form (AHC0002) (Appendix A.3 – Obtaining Alberta Health Resource Material).

It is important that Alberta Health be notified of any changes to your business mailing address, as this highly impacts the mailing out of your week Statement of Assessments.

> Alberta Health will not provide copies of the Statement of Assessment, unless the requester can **provide evidence** that the Statement of Assessment is no longer in their custody or control due to extenuating circumstances. This includes destruction or loss through fire, flood, natural disasters or the theft of paper copies, or the computer where electronic copies were stored.
>
> In all cases, Alberta Health will determine whether copies shall be provided and the time period for which the copies will be provided.

5.2 Statement of Assessment – Sample



SE400RS3 REL #: 0006056

Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

4 Statement Date: 2023/06/23
Page 1

1
Dr. John Doe
55,555 Alberta Way
Anywhere AB T9T 9T9

STATEMENT OF ASSESSMENT

5
Reference Nbrs
297535021

Business Arrangement 9999-999 2
Expected Payment Date 2023/06/30 3

6
Sequence Nbr
2

Patient Name	10 Chart Number	PHN	12 Claim Number	13 Service Start Date	14 Service Code	15 Claimed Amount	16 Assessed Amount	Mod Code	17 Mod Code	Mod Code	18 Result Code	Exp Code	19 Exp Code	20 Registration Number	21 RC
7 Doe, John		8 99999-9999													
9 Someone, Jane	11 00000000220881	22222-9999	QST23YC01557933	2023/06/16	03.04H	100.63	100.63				APLY				
Someone, Jane	00000000220881	22222-9999	QST23YC01557941	2023/06/16	03.01AA	182.20	182.20	TNTA04			APLY				
None, John	00000000220890	11111-9999	QST23YC01558220	2023/06/19	01.22	104.53	104.52	BMIANE	LVP75		APLY	63A			
None, John	00000000220890	11111-9999	QST23YC01558238	2023/06/19	01.14	167.08	167.08	BMIANE			APLY				
None, John	00000000220890	11111-9999	QST23YC01558246	2023/06/19	03.07AZ	86.68	86.68	CMGP01			APLY				

5.3 Statement of Assessment – Field Descriptions

To help you understand the Statement of Assessment, please refer to the sample photo above. The main elements on the statement have been numbered. Match the numbers on the sample with the explanations given below.

1. **Statement of Assessment Addressee**

Name and address of the person or organization designated to receive this statement.

2. **Business Arrangement**

Number indicating which business arrangement is to be paid.

3. **Expected Payment Date**

Date on which payment will be issued.

4. **Statement Date**

Date on which the assessment result was produced by Alberta Health.

5. **Reference Numbers**

ID number assigned to the Statement of Assessment produced.

6. **Sequence Number**

Sequential number indicating how many statements have been produced to date for your business arrangement.

7. **Physician**

Name of the physician who delivered health care services billed to the AHCIP.

8. **Practitioner Identification Number (PRAC ID)**

Unique number identifying the service provider.

9. **Service Recipient Name**

Patient's full name. If this field contains all asterisks (**) it means the processing system could not derive a surname from the information on the claim. Most common causes: the personal health number was invalid or was not provided, or the person data segment was insufficient.

10. **Chart Number**

Source reference number provided on the claim transaction by the practitioners.

11. **PHN**

Personal health number identifying each patient.

12. **Claim Number**

Number assigned to each claim by the submitter.

13. **Service Start Date**

Date the service was performed, started, or received.

14. **Service Code**

Unique code identifying the health service provided.

15. **Claimed Amount**

Amount claimed for the service provided.

16. **Assessed Amount**

Amount paid after application of assessment rules and other criteria.

17. **Modifier Code**

Explicit modifier code(s) affecting payment of an HSC.

18. **Result Code**

Code identifying whether a claim is being applied, held, or refused.

19. **Explanatory Code**

Code explaining the reason a claim is being held, reduced, refused or paid-at-zero. RVRSL in this field means the claim has been reassessed and the assessed amount has been changed. (See the Special Processing Codes section in the Explanatory Code Listing.)

20. **Registration Number**

Out-of-province registration number of the patient (applies to medical reciprocal program claims only).

21. **Recovery Code**

Code identifying the home province that will be invoiced to reimburse the AHCIP for claim expenses (applies to medical reciprocal program claims only).

5.4 Result Codes

When a claim appears on a Statement of Assessment, it displays one of three result codes: APLY, RFSE or HOLD.

1. **APLY** (Apply) means the claim has been processed and assessment is complete at this time. The claim may be paid in full, paid at a reduced rate, or "paid at zero."

   A paid-at-zero claim is not the same as a refused claim. It means that, although a valid service was provided, assessment has determined that payment is not warranted. For example, if a practitioner claims and is paid an all-inclusive fee for a procedure and claims for a follow-up visit provided within the all-inclusive period, the claim for the follow-up visit would be paid at zero, as it is included in the fee for the procedure.

   If you need to correct the data on a paid-at-zero claim or if you disagree with the reason why the claim was paid at zero, you must resubmit the claim with action code C (change) or R (reassess), as applicable. (Section 3.6 Action Codes and Section 5.5 - Following up on a Claim – Using the Correct Action Code.)

2. **RFSE** (Refuse) means the claim transaction was refused. This is usually due to invalid or missing claim data (such as the patient's PHN); however, it may be refused for some other reason, such as a general rule or note in the Schedule of Benefits, or an ineligible patient or practitioner.

   If you need to correct the data on a refused claim or if you disagree with the reason why the claim was refused, you must submit a new claim using action code A. Your submitter will assign a new claim number to the new submission. (Sections 3.6 - Action Codes and Section 5.5 - Following up on a Claim – Using the Correct Action Code.)

3. **HOLD** means the claim is being held, as it requires manual review. A claim on hold will reappear on a future Statement of Assessment with a final assessment outcome. **Do not resubmit a claim while it is on hold**.

> If the AHCIP makes a global claim reassessment due to a retroactive system change to a HSC general rule or category, and the result is a change in payment, a record of the reassessment will appear on the Statement of Assessment with the appropriate result code.

5.5 Following up on a Claim – Using the Correct Action Code

When reviewing a Statement of Assessment, you may find claims that have been refused, paid at zero, paid at a reduced rate, or adjusted in some way (e.g., a reversal). It is important that you review and understand the claim results. Refer to the Explanatory Code List, the general rules in the Schedule of Benefits and the notes associated with the HSC in the Procedure List section of the Schedule.

If you have to resubmit a claim, use the correct action code and claim number. Follow the instructions below:

Claim result	How to resubmit
1. The claim was refused (result code RFSE) due to **incorrect** claim data and you want to send a correction.	Create a new claim with a new claim number. a) Use **action code A** (add). b) Include a base claim segment with all applicable data. **Note:** Do not use action code C and the original claim number. The system will not recognize a claim number that was refused.
2. The claim was paid in full, reduced or paid at zero (result code APLY). The claim data is **incorrect,** and you want to send a correction.	Resubmit the claim using the original claim number. a) Use **action code C** (change). b) Complete the base claim segment showing how all the data should now be recorded. **Note:** You cannot use action code C to correct a patient PHN, a PRAC ID or a business arrangement number. Delete the original claim and submit a new claim with correct data. Use action code A and a new claim number.
3. The claim was reduced or paid at zero (result code APLY). The claim data is **correct,** and you want the AHCIP to review the assessment with additional information.	Resubmit the claim using the original claim number. a) Use **action code R** (reassess). b) Complete the supporting text segment with information to support your reassessment request. c) A base claim segment is optional.
4. The claim was paid in full, reduced or paid at zero (result code APLY), but you want to delete it because it should not have been submitted.	Resubmit the claim using the original claim number. a) Use **action code D** (delete). b) No base claim data is required.

Any add, change or reassess transactions must be received by Alberta Health within 90 days from the last transaction date.

5.6 Statement of Account

Along with payments, Alberta Health issues a weekly Statement of Account based on claims that have been assessed. The statement summarizes claim payment information and identifies any other payments or recoveries (e.g., Canada Revenue Agency assignments, manual payments, etc.).

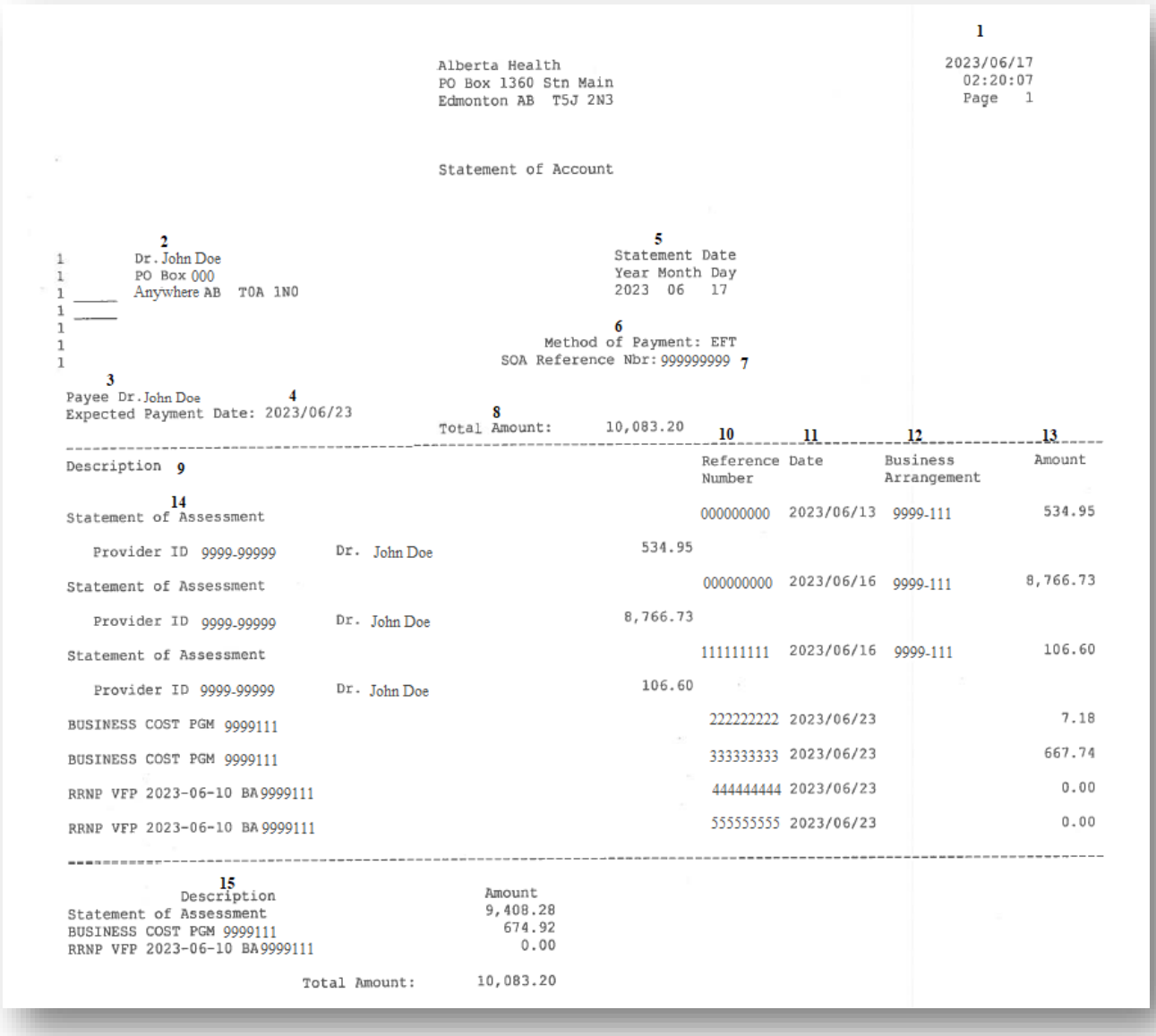
The total amount on the Statement of Account will match the amount deposited into your account on the expected payment date.

It is your responsibility to retain all Statements of Account until you have completed your reconciliations, no longer require them for tax purposes and have met the requirements in Section 15(2) of the *Alberta Health Care Insurance Regulation* which states that **billing information must be kept for six years.**

If a copy of the Statement of Account is required you must complete and submit the Request for Statement of Assessment/Account form AHC0002 (Appendix A.3 – Obtaining Alberta Health Resource Material).

> Alberta Health will not provide copies of the Statement of Account, unless the requester can **provide evidence** that the Statement of Account is no longer in their custody or control due to extenuating circumstances. This includes destruction or loss through fire, flood, natural disasters or the theft of paper copies, or the computer where electronic copies were stored.
>
> In all cases Alberta Health will determine whether copies shall be provided and the time period for which the copies will be provided.

5.7 Statement of Account - Sample



1

Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

2023/06/17
02:20:07
Page 1

Statement of Account

2
Dr. John Doe
PO Box 000
Anywhere AB T0A 1N0

5
Statement Date
Year Month Day
2023 06 17

6
Method of Payment: EFT
SOA Reference Nbr: 999999999 7

3
Payee Dr. John Doe 4
Expected Payment Date: 2023/06/23

8
Total Amount: 10,083.20

Description 9			10 Reference Number	11 Date	12 Business Arrangement	13 Amount
14 Statement of Assessment			000000000	2023/06/13	9999-111	534.95
Provider ID 9999-99999	Dr. John Doe	534.95				
Statement of Assessment			000000000	2023/06/16	9999-111	8,766.73
Provider ID 9999-99999	Dr. John Doe	8,766.73				
Statement of Assessment			111111111	2023/06/16	9999-111	106.60
Provider ID 9999-99999	Dr. John Doe	106.60				
BUSINESS COST PGM 9999111			222222222	2023/06/23		7.18
BUSINESS COST PGM 9999111			333333333	2023/06/23		667.74
RRNP VFP 2023-06-10 BA9999111			444444444	2023/06/23		0.00
RRNP VFP 2023-06-10 BA9999111			555555555	2023/06/23		0.00

15 Description	Amount
Statement of Assessment	9,408.28
BUSINESS COST PGM 9999111	674.92
RRNP VFP 2023-06-10 BA9999111	0.00
Total Amount:	10,083.20

5.8 Statement of Account – Field Descriptions

Please refer to sample photo above and match the numbered elements on the sample statement with the explanations given below.

1. Date and time the report was printed.
2. Name and address to which the Statement of Account is mailed.
3. Name of the payment recipient.
4. Date on which payment will be issued.
5. Date on which this statement information was produced.
6. Means by which payment will be made. Electronic funds transfer (EFT) is the only method Alberta Health uses to pay claims submitted by Alberta practitioners.
7. ID number assigned to each Statement of Account.
8. Amount to be paid on the expected payment date.
9. Explanation identifying each source of payment or recovery.
10. ID number assigned to uniquely identify a particular Statement of Assessment.
11. Date on which the Statement of Assessment was produced.
12. Number indicating which business arrangement is to be paid.
13. Grand total for each item listed on this statement.
14. Individual Statements of Assessment that affect this Statement of Account.
15. Summary of all components that resulted in the total amount.

5.9 Monitoring and Compliance

The AHCIP compensates providers in accordance with the Schedule of Benefits. Under the AHCIP claims are paid to providers once claims have been submitted, received, and processed.

To ensure accountability of the AHCIP, the Health Protection Branch monitors the health care providers' claims through regular reviews that assess compliance with the applicable legislation. Statistical and risk assessment methodologies are used to identify potential non-compliance in the claims that were submitted under the AHCIP. Subsequently, compliance reviews are triggered for the identified providers. Occasionally, complaints regarding providers' claims are received, and may trigger a compliance review.

Alberta Health's compliance review process typically involves, but is not limited to:

- A review of a sample of claims data for a specific period of time to determine compliance.
- A review of samples of patients' records, or other records required to verify the errors or issues.
- Communication with providers to inform via letters to:
  - Initiate compliance review
  - Request documentation
  - Notify of compliant and non-compliant findings within the review
  - Gather additional information from the provider
  - Conclude the compliance review findings
  - Provide avenues of appeal
- Extrapolation of the results from the sample to the population of paid claims in the review period.

This compliance review is an interactive and administratively fair process through which providers have the opportunity to provide documentation and comments including a response to the compliance review findings. The compliance review process includes:

- Notice of compliance review;
- Submission of patient records and documentation by the provider;
- Review of claims and documentation by the Health Protection Branch;
- Notice of Findings issued by the Health Protection Branch;
- Response submitted by the provider and subsequent review;
- Notice of Reassessment issued by the Health Protection Branch;
- Recovery of any overpayments determined by the Health Protection Branch or appeal avenues pursued by the Provider.

In addition, Alberta Health may visit a provider's office to better understand his or her practice, conduct interviews and to view any documentation required for the compliance review. Patients may also be contacted to verify the services that were provided.

Providers must ensure that their records are complete, accurate and support the services provided and benefits claimed. This requires providers to understand and apply the Schedule of Benefits and to ensure that their billing staff understand the Alberta Health rules and submit claims appropriately.

Documentation in patient health records must be completed in a manner deemed acceptable by the Minister.

The original documentation relating to the goods or services provided must be retained for not less than six years and make the documentation available to Alberta Health on request.

Other applicable legislation includes the *Alberta Health Care Insurance Act, the Hospitals Act, the Health Information Act, the Nursing Home Act, the Nursing Home General Regulation, the Alberta Health Care Insurance Regulation, the Claims for Benefits Regulation, and the Health Facilities Act.*

Other applicable regulations include *Optometric Benefits Regulations, Podiatric Benefits Regulation, Podiatric Surgery Benefits Regulation, Oral and Maxillofacial Surgery Benefits Regulation*.

In Addition: College of Physicians and Surgeons of Alberta - Standards of Practice.

Questions regarding monitoring and compliance can be sent by e-mail to MIbranch@gov.ab.ca. or via mail to the Director, Audit and Compliance Assurance Unit, Compliance and Monitoring Branch, 24th floor ATB Place, 10025 Jasper Avenue NW, Edmonton, Alberta, T5J 1S6. Further information can be found on the Alberta Health website at https://www.alberta.ca/health-professionals-audit-and-compliance-assurance.aspx.

6.0 Schedules of Benefits

The Schedules of Benefits are updated periodically and posted on our website at https://www.alberta.ca/fees-health-professionals.aspx. Please check regularly to ensure you are using the most recent edition of the Schedule for your claim submissions.

The Schedule of Benefits for every discipline consist of the following sections:

General Rules	Defines the circumstances under which insured services are paid.
Procedure List	Lists insured services. This section contains HSC and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.
Price List	Lists all HSC and their applicable modifiers. This section indicates how fees are modified by specific circumstances. It displays the category code for each service so practitioners can identify visits, tests, minor and major procedures.
Explanatory Codes	List of codes indicating why an amount claimed has been reduced, paid at zero, refused or otherwise changed.
Fee Modifier Definitions	Describes all implicit and explicit modifier codes used by the AHCIP processing system to determine amounts payable.

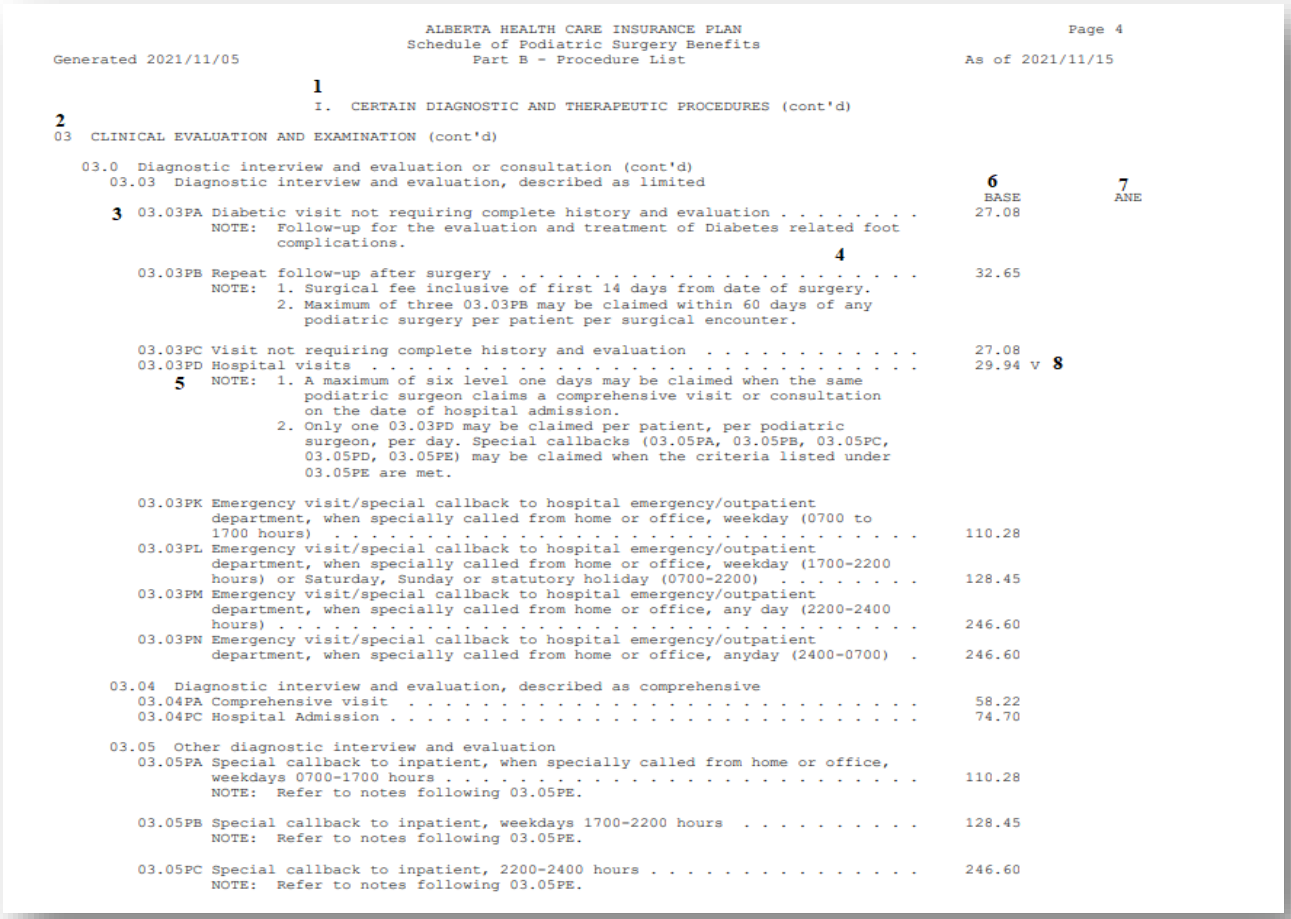
6.1 Procedure List

This component of the Schedule of Benefits lists all insured services. To help you understand how the Procedure List works, please refer to the sample page from the Schedule of Podiatry Benefits in the next section of this guide. All the field headings and formats are the same for every discipline schedule. The main elements have been numbered on the sample. Match the numbered elements with the explanations given below.

1. Roman numerals and general heading for the particular section, e.g., I. CERTAIN DIAGNOSTIC AND THERAPUETIC PROCEDURES.
2. This field identifies the section heading.
3. The HSC for the service performed.
4. A description of the HSC.
5. The NOTE field contains special instructions for a HSC.
6. BASE amount is the fee for the service before application of any modifiers. This may be a dollar amount or the code BY ASSESS.
7. The ANE field indicates the anaesthetic fee for the service, if applicable. In the Schedules of Benefits where an anaesthetic fee is listed for a procedure, it would only be claimed by the practitioner providing the related anaesthetic service.
8. The letter V beside the base rate means the fee payable varies depending on the practitioner skill and/or specific modifiers associated with the HSC.

If BY ASSESS is indicated under the BASE amount, the fee payable for the procedure depends on supporting information that must be

6.2 Procedure List – Sample Page



ALBERTA HEALTH CARE INSURANCE PLAN — Page 4
Schedule of Podiatric Surgery Benefits
Generated 2021/11/05 — Part B - Procedure List — As of 2021/11/15

1
I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

2
03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

		6 BASE	7 ANE
03.0	Diagnostic interview and evaluation or consultation (cont'd)		
03.03	Diagnostic interview and evaluation, described as limited		
3 03.03PA	Diabetic visit not requiring complete history and evaluation NOTE: Follow-up for the evaluation and treatment of Diabetes related foot complications.	27.08	
4 03.03PB	Repeat follow-up after surgery NOTE: 1. Surgical fee inclusive of first 14 days from date of surgery. 2. Maximum of three 03.03PB may be claimed within 60 days of any podiatric surgery per patient per surgical encounter.	32.65	
03.03PC	Visit not requiring complete history and evaluation	27.08	
03.03PD	Hospital visits	29.94 v 8	
5	NOTE: 1. A maximum of six level one days may be claimed when the same podiatric surgeon claims a comprehensive visit or consultation on the date of hospital admission. 2. Only one 03.03PD may be claimed per patient, per podiatric surgeon, per day. Special callbacks (03.05PA, 03.05PB, 03.05PC, 03.05PD, 03.05PE) may be claimed when the criteria listed under 03.05PE are met.		
03.03PK	Emergency visit/special callback to hospital emergency/outpatient department, when specially called from home or office, weekday (0700 to 1700 hours)	110.28	
03.03PL	Emergency visit/special callback to hospital emergency/outpatient department, when specially called from home or office, weekday (1700-2200 hours) or Saturday, Sunday or statutory holiday (0700-2200)	128.45	
03.03PM	Emergency visit/special callback to hospital emergency/outpatient department, when specially called from home or office, any day (2200-2400 hours)	246.60	
03.03PN	Emergency visit/special callback to hospital emergency/outpatient department, when specially called from home or office, anyday (2400-0700)	246.60	
03.04	Diagnostic interview and evaluation, described as comprehensive		
03.04PA	Comprehensive visit	58.22	
03.04PC	Hospital Admission	74.70	
03.05	Other diagnostic interview and evaluation		
03.05PA	Special callback to inpatient, when specially called from home or office, weekdays 0700-1700 hours NOTE: Refer to notes following 03.05PE.	110.28	
03.05PB	Special callback to inpatient, weekdays 1700-2200 hours NOTE: Refer to notes following 03.05PE.	128.45	
03.05PC	Special callback to inpatient, 2200-2400 hours NOTE: Refer to notes following 03.05PE.	246.60	

6.3 Price List

This component of the Schedules of Benefits displays the base fee for the different HSC, as well as modifier definitions arranged by type, code, and description.

A sample page from the Podiatry Price List appears on the next page of this guide. The fields on the sample have been numbered and the explanations appear below, corresponding by number.

1. 03.05PF is the HSC. See the Procedure List for a description of this code.
2. $59.73 is the base fee for the procedure.
3. This field lists all modifier types that apply to this HSC.
4. A listing of all modifier codes that affect payment, applicable to this HSC.
5. The letter Y in this field identifies each explicit modifier. When applicable, these must be entered on a claim prior to submission.

6. This field shows what effect the modifier has on the base amount. Example: When the modifier code is used and more than one call is entered on the claim, the implicit modifier is assigned by the claims processing system. The base fee is then replaced.

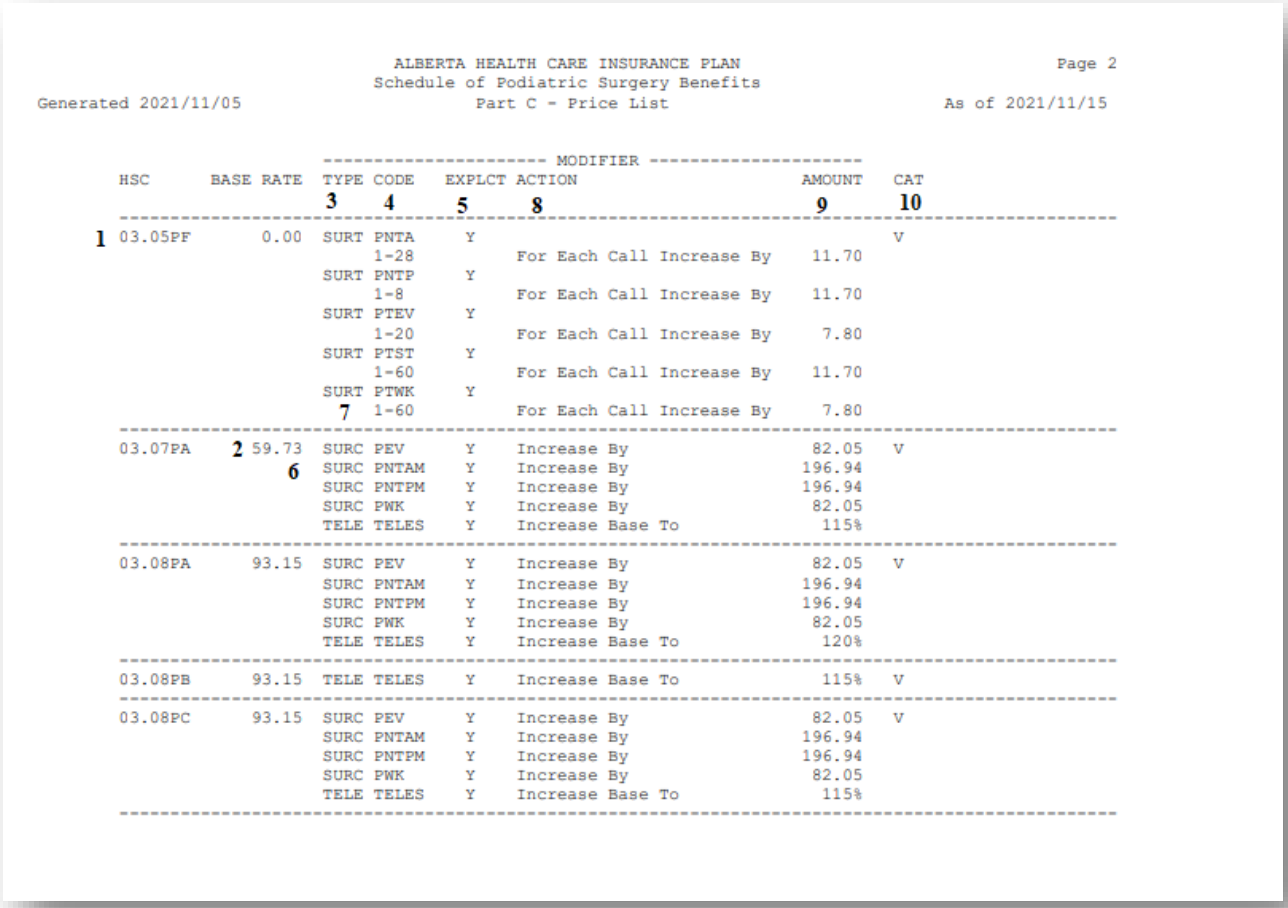
7. This field indicates the fee for each modifier code.

8. This field shows what effect the modifier has on the base amount. Example: When role modifier is entered on a claim for HSC, the base amount is replaced by the amount in the next column.

9. This field indicates the fee for each modifier code. Example: The fee for HSC is increased by the amount in that column.

10. The category code for each HSC.

6.4 Price List – Sample Page



ALBERTA HEALTH CARE INSURANCE PLAN — Page 2
Schedule of Podiatric Surgery Benefits
Generated 2021/11/05 — Part C - Price List — As of 2021/11/15

HSC	BASE RATE	MODIFIER TYPE CODE (3 4)	EXPLCT (5)	ACTION (8)	AMOUNT (9)	CAT (10)
1 03.05PF	0.00	SURT PNTA	Y			V
		1-28		For Each Call Increase By	11.70	
		SURT PNTP	Y			
		1-8		For Each Call Increase By	11.70	
		SURT PTEV	Y			
		1-20		For Each Call Increase By	7.80	
		SURT PTST	Y			
		1-60		For Each Call Increase By	11.70	
		SURT PTWK	Y			
		7 1-60		For Each Call Increase By	7.80	
03.07PA	2 59.73	SURC PEV	Y	Increase By	82.05	V
6		SURC PNTAM	Y	Increase By	196.94	
		SURC PNTPM	Y	Increase By	196.94	
		SURC PWK	Y	Increase By	82.05	
		TELE TELES	Y	Increase Base To	115%	
03.08PA	93.15	SURC PEV	Y	Increase By	82.05	V
		SURC PNTAM	Y	Increase By	196.94	
		SURC PNTPM	Y	Increase By	196.94	
		SURC PWK	Y	Increase By	82.05	
		TELE TELES	Y	Increase Base To	120%	
03.08PB	93.15	TELE TELES	Y	Increase Base To	115%	V
03.08PC	93.15	SURC PEV	Y	Increase By	82.05	V
		SURC PNTAM	Y	Increase By	196.94	
		SURC PNTPM	Y	Increase By	196.94	
		SURC PWK	Y	Increase By	82.05	
		TELE TELES	Y	Increase Base To	115%	

APPENDICES

Appendix A – Contact Information and Resources

Alberta Health's Provider Relationship and Claims Unit is available to address inquiries from allied health practitioners for clarification of general rules and billing policies, which can be submitted in writing to Health.HCIPAProviderClaims@gov.ab.ca.

- This email address is exclusively intended for clarification requests concerning general rules and billing policies, and not for any other purpose.
- Email correspondence provides both parties with documentation for future reference. It also benefits practitioners and Alberta Health by reducing the risk of misunderstanding regarding information requested and verifies that the correct information is available to the practitioners.

All registration forms and inquiries pertaining to practitioner and facility requests, or any changes to an existing practice (e.g., business mailing address, business arrangement, skill, submitter, banking information, etc.) can be sent by e-mail to Health.Pracforms@gov.ab.ca or by fax to 780-422-3552.

A.1 Additional Alberta Health Contact Information

Mailing address/Fax Number

Correspondence can be mailed to:

Claims Management Unit
Health Insurance Programs Branch
Alberta Health
PO Box 1360 Station Main
Edmonton AB T5J 2N3

Fax: 780-422-3552

Telephone/Contact

Check an Alberta patient's PHN and/or its status for a specific date	Phone: **780-422-6257** Toll-free **1-888-422-6257** (24 hour access - automated service, no access to staff.) **Do not give out this number** to the general public.
Information about: • H-Link submitter accreditation • Application support	Phone**: 780-644-7643** (8:15 a.m. – 4:30 p.m.) **Do not give out this number** to the general public.
Request a replacement Statement of Assessment • You will need to provide your Business Arrangement number and the statement date • Ensure 15 business days have elapsed since the statement date before calling	Phone: **780-415-8731** (24 hour access) The public also uses this number to request other information.

General inquiries about AHCIP coverage and benefits	Phone: **780-427-1432** (8:15 a.m. – 4:30 p.m.) The public also uses this number to request information.

A.2 Alberta Health Resources

To assist allied health practitioners and their staff with the submission of claims to the AHCIP, Alberta Health provides a variety of resources. Practitioners are encouraged to make these resources easily accessible for reference and use by their staff as well. Maximizing the tools available enables practitioner offices to become more self-sufficient and cost effective.

As new documents are posted and updated regularly, practitioners are encouraged to check online regularly to ensure that they are referencing the most current documents and information.

- The following resources are available on the Government of Alberta website at https://www.alberta.ca/fees-health-professionals.aspx.
  - SOMB
  - Physician's Resource Guide
  - Diagnostic Code Supplement (ICD9)
  - Facility Listing
- Bulletins, which contain information about SOMB amendments and advice regarding claim submissions, clarification of assessment, etc., are produced as necessary and posted at: https://www.alberta.ca/bulletins-for-health-professionals.aspx.
- Health business user forms are located at https://www.alberta.ca/health-professional-business- forms.aspx.

Practitioner reference documents (schedules of benefits, listings, forms, etc.) available on our website require Adobe Reader software for viewing. This software is available at no cost via the links adjacent to these resources.

A.3 Obtaining Alberta Health Legislation and Regulations

The *Canada Health Act* is Canada's federal legislation for publicly funded health care insurance. The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." The act also establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfil to receive the full federal cash contribution under the Canada Health Transfer (CHT). The *Canada Health Act* can be found on the website at http://laws-lois.justice.gc.ca/eng/acts/C-6/.

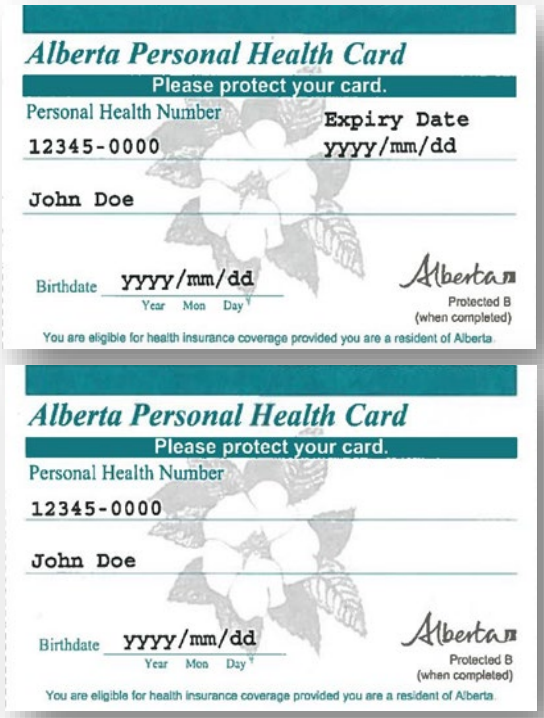
Alberta's health care legislation was developed to be consistent with the values of the *Canada Health Act*. Copies of Alberta Health legislation and regulations can be viewed or downloaded from the Alberta King's Printer website at https://kings-printer.alberta.ca/Laws_Online.cfm.

Appendix B – Valid Provincial/Territorial Health Cards

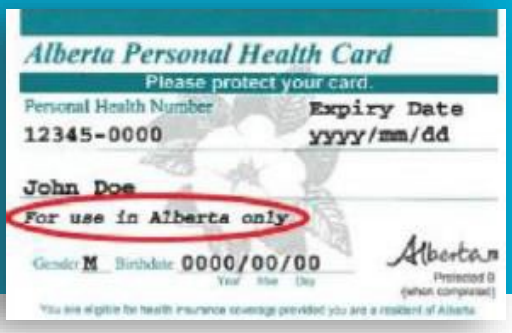
Alberta Health does not provide copies of the Provincial/Territorial Health Care Card Poster. As revised versions of the poster are released by Health Canada, they are posted on the Alberta Health website at https://www.alberta.ca/health-professional-business-forms.aspx.

ALBERTA

- Alberta personal health cards are not issued annually. New residents and newborns are issued cards when they are registered.
- Replacement cards are issued upon request.
- Information on the card includes the individual's nine-digit personal health number (PHN), name, gender, and date of birth.
- Personal Health Cards issued to permanent residents do not have an expiry date.
- Personal Health Cards issued to temporary residents such as foreign workers, students and their dependants' have an expiry date.



Alberta issues a health card to persons eligible for benefits under Alberta's Ukrainian Evacuee Temporary Health Benefits Program. This card is valid only in the province of Alberta and cannot be used for Reciprocal Billing.



BRITISH COLUMBIA

Recovery Code – BC

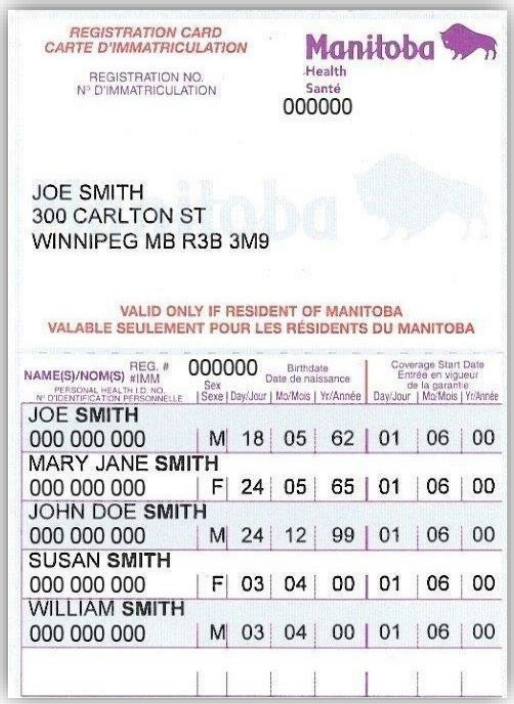
- The regular card is on a white background with the word “CareCard” filling the background in grey.
- The words “British Columbia Care” are blue, and “Card” is red. The flag is red, blue, white, and yellow. Plan member information is in black.
- A gold CareCard is issued to seniors a few weeks before they reach age 65. It is gold with the words “British Columbia CareCard FOR SENIORS” in white. Plan information is also in white.

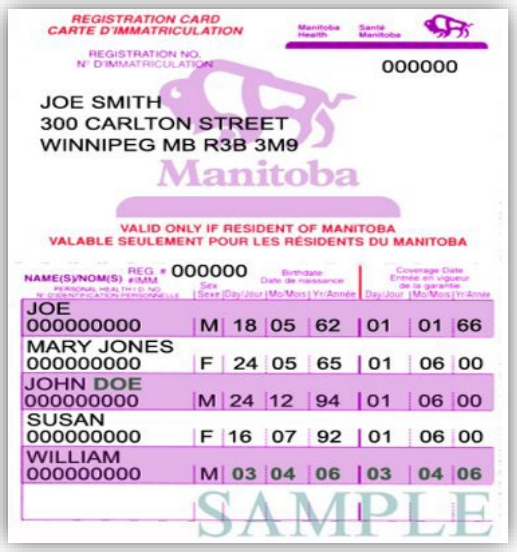
- On February 15, 2013, the B.C. provincial government introduced the BC Services Card, which will be phased in over a five-year period. The new card replaces the CareCard. It is secure government-issued identification that British Columbians can use to prove their identity and access provincially-funded health services.
- BC Service Card may acts as both a Healthcare Card (access to publicly funded health services through the Medical Service Plan (MSP)) and/or a Drivers ID/Photo ID.
- Some BC residents may have a non-photo BC Services card. These residents include: children and youth under 19, adults with temporary immigration status, adults 75 and older. Additional Information can be found on the BC website: https://www2.gov.bc.ca/gov/content/governments/government-id/bc-services-card.

MANITOBA

Recovery Code – MB

- Manitoba Health issues a card (or registration certificate) to all Manitoba residents.
- It includes a nine-digit lifetime identification number for each family member.
- The white paper card has purple and red print and includes the previous six-digit family or single person's registration number, name and address of Manitoba resident, family member's given name and alternate (if applicable), sex, birth date, effective date of coverage, and nine-digit Personal Health Identification Number (PHIN.)

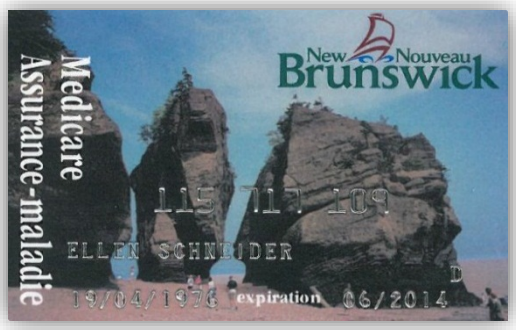


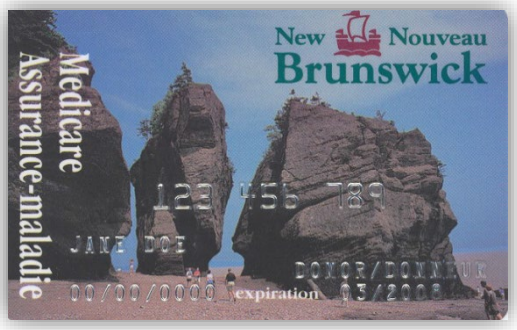


NEW BRUNSWICK

Recovery Code – NB

- The plastic card with a magnetic strip depicts a New Brunswick scene of the Flowerpot Rocks-Hopewell Cape.
- The New Brunswick logo is displayed in the upper right corner.
- The card contains the nine-digit Medicare registration number, the subscriber's name, date of birth and expiry date of the card.

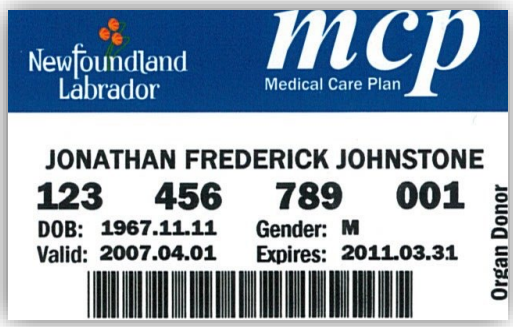




NEW FOUNDLAND AND LABRADOR

Recovery Code – NL

- The Medical Care Plan (MCP) cards contain an individual's name, gender, MCP number and birth date.
- The cards have an expiry date to allow the Department of Health and Community Services to periodically update the MCP database and provide an improved mechanism for accountability.
- Effective November 1, 2017, barcodes have been added to newly issued MCP cards to enable a beneficiary to self-register for scheduled appointments at health care facilities throughout the province.



NORTHWEST TERRITORIES

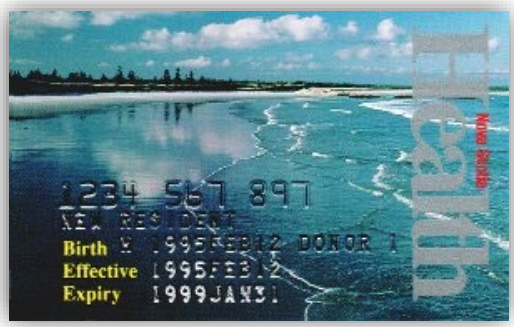
Recovery Code – NT

- The Northwest Territories (NWT) health care card shows the new visual elements of the Government of the NWT.
- The card includes the insured person's health insurance number, name, and the expiry date of the card.

NOVA SCOTIA

Recovery Code – NS

- Nova Scotia's health card is made of plastic and features a beachscape with clouds in the distance against a blue background.
- The words Nova Scotia (red) and Health (silver) are printed along the right edge.
- The card includes the insured person's ten-digit health insurance number, name, gender and date of birth; the effective date of coverage; and the expiry date of the card. All dates are yyyy/mmm/dd. The numbers and letters are embossed and tipped with silver foil.

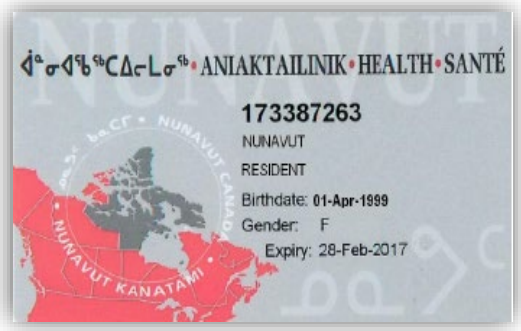


Nova Scotia issues a health card that is valid only in Nova Scotia. Persons entering Nova Scotia with a work or student visa may be provided temporary coverage for insured health services. The card clearly states that coverage is valid only in the province of Nova Scotia and cannot be used for Reciprocal Billing

NUNAVUT

Recovery Code – NU

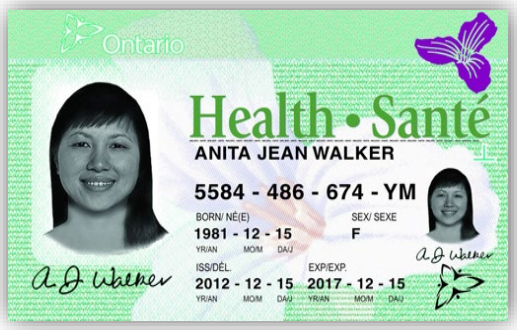
- The Nunavut health card is made of pale grey plastic.
- It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages.
- In the upper portion of the card the word NUNAVUT appears in pale grey, with the word HEALTH superimposed in four languages.
- The card shows the following information: the nine-digit health insurance number, name and date of birth of the insured person, the address and telephone number of the Nunavut administrative services, the signature of the cardholder, as well as the card's expiry date.

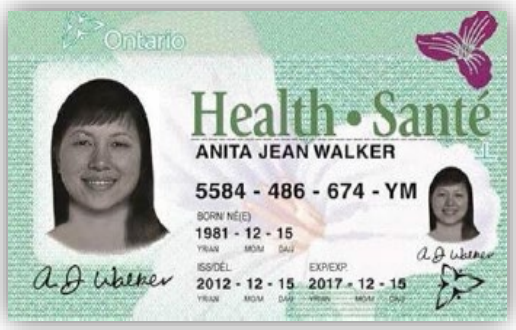


ONTARIO

Recovery Code – ON

- Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services, provided they are valid and belong to the person presenting the card.
- The red and white health card shows the Personal Health Number and name.
- The photo health card contains a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, and the beneficiary's month and year of birth.
- When submitting a medical reciprocal claim for an ON patient, the submitter should not enter the last two letters i.e. enter 5584486674 only. Omit the YM.A
- Cards must be signed. Red and white cards are signed on the back, while the photo card is signed on the front.
- Children under the age of 15 ½ years have health cards that are exempt from both photo and signature.

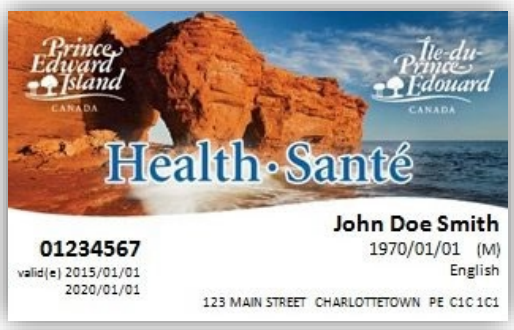




PRINCE EDWARD ISLAND

Recovery Code – PE

- A new bilingual health care card for Prince Edward Island (PEI) came into effect in February 2016 showing a design that prominently features the stunning Darnley shoreline.
- The new card will feature on the front the individual's preferred language of service. The back of the card may include a red heart which shows the owner's intention to be an organ donor.
- The orange health card will be phased out over the next five years as the existing cards expire. Health PEI and other government and non-government organizations will continue to accept the orange health card as long as it is valid.
- Both cards show a unique 8-digit lifetime identification number, the given name(s), birth date and gender of the resident, as well as the expiry date of the health card.



QUEBEC

Recovery Code – QC

- The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan.
- The resident's photograph and signature are both digitized and incorporated into the card. Cards issued to persons not required to provide a photo and a signature, such as children under age 14, have no photo or signature spaces, while cards issued to persons exempt from providing their photo, their signature or both, are marked "exempté" in the appropriate space(s)
- Information appearing on the Health Insurance Card include: resident's first and last name, birth date and gender of the resident, as well as the expiry date (year and month).
- All cards are valid until the last day of the month in which they expire.

In January 2018, Quebec started issuing a new version of their Health Care Card displayed below. Quebec residents will receive the new card when their old card expires. In the meantime the old version remains valid.

SASKATCHEWAN

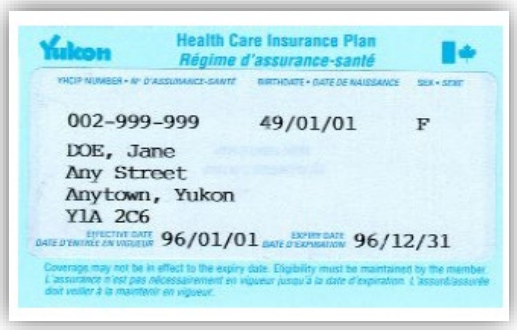
Recovery Code – SK

- The plastic cards are blue above and grey below a green, yellow and white stripe.
- Cards contain a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, beneficiary's month and year of birth and 8-digit Family/Beneficiary number.

YUKON

Recovery Code – YT

- The newer style Pharmacare card is a light green with a medium green logo and text. The label affixed to both cards is the same style and colour.
- A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card.
- The green health care card entitles holders to all seniors' benefits, hospital and practitioner services. Persons are eligible for the card if they are a Yukon resident aged 65 years or older, or if they are 60 years of age or older and married to a living Yukon resident who is 65 years of age or older.



Appendix C – Province/Territory Health Plan Contact Information

Newfoundland and Labrador

Medical Care Plan (MCP)
Toll-Free 1-800-563-1557
Tel: 709-292-4027
E-mail: healthinfo@gov.nl.ca
Website:
http://www.health.gov.nl.ca/health/department/contact.html#proservbranch
Time limit: 3 months

Prince Edward Island

PEI Medicare
General Inquiry: 902-368-6414
Toll free (throughout Canada): 1-800-321-5492
Website: Contact Us | Government of Prince Edward Island
Time limit: 3 months

Nova Scotia

Nova Scotia Medical Services Insurance (MSI)
General Inquiries: 902-496-7008
E-mail: MSI@medavie.ca
Website: Contact MSI | novascotia.ca
Time limit: 3 months

New Brunswick

New Brunswick Medicare
Main Line: 506-457-4800
Outside the province: 1-506-684-7901
E-mail: http://www.gnb.ca/0051/mail-e.asp
Website:
http://www2.gnb.ca/content/gnb/en/departments/health/contacts/dept_renderer.141.html#contacts
Time limit: 3 months

Québec

Service de l'évolution des processus
Régie de l'assurance maladie du Québec
Québec City: 418 646-4636
Montréal: 514-864-3411
Website: www.ramq.gouv.qc.ca/en/contact-us/citizens/Pages/contact-us.aspx
Time limit: 3 months

Ontario

Ontario Health Insurance Plan (OHIP)
Service Ontario, Infoline: 1-866-532-3161
TTY: 1-800-387-5559
Website: https://www.ontario.ca/page/your-health
Time limit: 6 months

Manitoba

Registration & Client Services Manitoba Health
General Inquiries Line: 204-786-7101
Toll free in North America: 1-800-392-1207
Email: insuredben@gov.mb.ca
Website: Contact Us | Health | Province of Manitoba (gov.mb.ca)
Time limit: 6 months

Saskatchewan

Primary Health Services
Saskatchewan Health Registration: 306-787-3251
Toll free within the province: 1-800-667-7766
E-mail: info@health.gov.sk.ca
Website:
https://www.saskatchewan.ca/government/government-structure/ministries/health
Time limit: 6 months

British Columbia

Health Insurance BC Medical Services Plan (MSP)
Telephone: 604-683-7151
Outside BC: 1-800-663-7100
E-mail: mspenquiries@hibc.gov.bc.ca
Website: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents-contact-us
Time limit: 3 months

Yukon Territory

Health Care Insurance Plan
Telephone: 867-667-5209
Toll Free within the Territory: 1-800-661-0408 ext. 5209
E-mail: hss@gov.yk.ca
Website: Apply for a Yukon health care card | Government of Yukon
Time limit: 6 months

Northwest Territories

NWT Health Care Plan
Registrar General, Health Services Administration
Telephone: 867-669-2388
Toll free: 1-800-661-0830
E-mail: healthcarecard@gov.nt.ca
Website: www.hss.gov.nt.ca/contact-us
Time limit: 12 months

Nunavut

Nunavut Health Care Plan
Telephone: 867-645-8001
Toll free (throughout Canada): 1-800-661-0833
E-mail: nhip@gov.nu.ca
Website: Contact us | Government of Nunavut
Time limit: 6 months

Appendix D – Glossary

Accredited submitter
An organization or individual accredited by Alberta Health to transmit electronic claims and retrieve results of transactions for practitioners.

Action code
One of four codes that must accompany every AHCIP claim. The codes are: A (**add** a new claim), C (**change** a previously accepted claim), D (**delete** a previously accepted claim), and R (**reassess** a claim taking into account additional supporting text information).

Alberta Health
The provincial government ministry responsible for setting, monitoring and enforcing provincial health policy and standards; some health and seniors programs; and managing health capital planning, procurement and outcome measures.

Alberta Health Care Insurance Plan (AHCIP)
A non-profit publicly funded plan administered and operated under the *Alberta Health Care Insurance Act* and Regulations to pay benefits for insured health services to eligible residents of Alberta.

Alberta Health Services
The provincial health authority responsible for overseeing the planning and delivery of health supports and services to adults and children living in Alberta.

Applied
A claim that has been processed and the benefit amount determined. An applied claim will display APLY in the Result Code field on the Statement of Assessment.

Auxiliary hospital
A facility designated for the provision of medical services to in-patients who have long-term chronic illnesses, diseases or infirmities.

Balance billing (or extra billing)
Amount charged by an opted-in practitioner to a patient above the current rate listed in the Schedule of Medical Benefits. This is not allowed under section 9(1) of the *Alberta Health Care Insurance Act*.

Basic health benefits
Services deemed medically required according to the *Canada Health Act* and provided by practitioners, osteopaths and dental surgeons.

Benefit year
A period of 12 consecutive months commencing on July 1 in each year.

Bulletin
Periodic notices issued by Alberta Health to highlight or clarify changes in claim submissions and assessments and/or to provide practitioners with other important information.

Business arrangement
A mandatory agreement between a practitioner and Alberta Health detailing payment arrangements for insured health services. Defines contract holder, practitioners involved, payee and accredited submitter. Practitioners may have and/or be part of more than one business arrangement.

Business arrangement number

Assigned by Alberta Health, it defines the contract holder, the service provider and the payee; all of whom could be the same or different stakeholders. All practitioners registered with Alberta Health must have or be part of a BA in order to claim for services.

By assessment
A specific procedure with a HSC but no base rate listed in the Schedule of Benefits. Practitioners must provide supporting text with the claim for the AHCIP to determine a payment amount.

CCP
The Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures. CCP codes are widely used in practitioner benefits schedules, including Alberta's Schedule of Medical Benefits.

Certification
Official recognition by a licensing professional body that a practitioner has qualifications or capabilities to perform specific health services. Evidence of certification must be provided to Alberta Health by the licensing body to ensure appropriate payments can be issued.

Claim number
An individual number assigned to each claim by the submitter.

CLASS
An acronym for Claims Assessment System, which is the processing and control system for all health care-related claims for insured services provided through the AHCIP.

Contract holder

The person, Professional Corporation, or organization that enters into a Business Arrangement with Alberta Health.

Default skill
The primary skill used by a practitioner to perform all or most services. Practitioner with multiple skills can designate a default skill. When the Skill field on a claim transaction is left blank, the claim is automatically processed using the default skill.

Dependant(s)
Individuals registered under the name of the person responsible for the maintenance and support of the family. Normally, dependants are members of that person's immediate family. For example, spouse, adult interdependent partner, children. (See Registrant.)

Diagnostic code
A code that identifies a specific medical condition. It may have three to six characters, including a decimal point.

Direct billing
Billing the patient directly for insured services. The practitioner then submits an electronic pay-to-patient claim or provides the patient with the required claim documentation. The patient would then be reimbursed by the AHCIP, if eligible.

Direct deposit (or electronic funds transfer)
The method by which AHCIP benefit payments are transferred directly into a practitioner's, organization's or professional corporation's bank account.

Discipline
The specific branch or field of study in which a practitioner has been licensed to practise (e.g., physician, dentist, optometrist, etc.).

Electronic claim submission
The method used to submit claims electronically to the Alberta Health mainframe. In-province practitioner claims are normally submitted via an accredited submitter using H-Link.

Excluded services
Medical services not payable under Canada's medical reciprocal program.

Explanatory code
The code indicating why an amount claimed has been reduced, paid at zero, refused or otherwise changed. Appears on the weekly Statement of Assessment to practitioner and on the Statement of Account to patients who have been directly billed.

Facility
The physical location, such as a hospital or clinic, where health services are routinely provided. All formally recognized or accredited facilities are registered by Alberta Health.

Facility number
An identifying number assigned by Alberta Health to a facility where health services are routinely provided.

Fee modifier code
A code used on a claim in conjunction with a HSC to increase or decrease the base payment amount for a health service. Modifiers are explicit or implicit. Explicit modifiers are entered by the practitioner. Implicit modifiers are entered by the AHCIP claim processing system based on pre-stored information.

Functional centre
A specific area within a facility where health services are provided. Benefit payments can vary according to the functional centre. Examples of functional centres within a hospital include clinic, surgical and emergency department.

General hospital
A hospital providing diagnostic services and facilities for medical or surgical treatment in the acute phase for adults and children and obstetrical care.

Governing organization
A professional entity with a mandate to certify or license practitioners or facilities.

Health service code (HSC)
A code that identifies services and procedures listed in the Schedule of Benefits. Complete code descriptions can be found in the Procedure List in the applicable Schedule.

Health service provider
A licensed individual providing health services.

H-Link
An electronic communication system that connects clients' personal computers to the Alberta Health mainframe. Used to send claim information between Alberta Health and its clients.

Modifier code
(See **Fee modifier code**.)

Nursing home
A facility designated for the provision of nursing home care.

Opting in
Participating in the publicly funded health care insurance plan.

Opting out
Not participating in the publicly funded health care insurance plan. Services provided by an opted-out practitioners or to an opted-out Alberta resident are to be paid by the resident.

Paid at zero
The AHCIP term indicating that an insured service has been provided but assessment has determined that a payment is not warranted. Example: the bunionectomy fee includes related pre-and post- operative services. A claim for a related visit within the defined pre- and post-operative period by the same practitioner would be paid at zero.

PHN
Personal Health Number. The number assigned by Alberta Health to any service recipient or organization registered with the AHCIP. PHNs are a type of Unique Lifetime Identifier (ULI).

Plan benefit
Compensation associated with provision of insured health services, as governed by the *Alberta Health Care Insurance Act*. Practitioners are paid benefits according to an approved schedule of fees. Benefits may also be paid to eligible Alberta residents who are billed directly after receiving an insured service.

Practitioner
A licensed individual who provides health services.

Practitioner Identification Number (PRAC ID)
An identifying number assigned to each practitioner registered with the AHCIP for claim processing, reporting, referral and payment purposes. A PRAC ID is nine numeric characters long, with a four-digit set and a five-digit set separated by a dash (e.g., 1234–56789).

Provider
(See Health service provider.)

Registrant
The person who has accepted primary responsibility for the maintenance and support of the family.

Registration number
A number assigned to an Alberta resident. It affirms eligibility for AHCIP coverage. Similarly, residents of other provinces are assigned an identifier by their home province/territory health plan.

Resident of Alberta
A person who is legally entitled to be or to remain in Canada and makes his/her permanent home in Alberta; does not include tourists, transients or visitors to Alberta. A resident is not entitled to coverage under the AHCIP if he/she is a member of the Canadian Armed Forces, a person serving a term of imprisonment in a federal correctional facility, or has not completed the waiting period prescribed by the regulations.

Result code
One of three codes shown on a Statement of Assessment that identifies the results of a processed claim. The codes are APLY (applied), HOLD (held) and RFSE (refused).

Schedule of Benefits
Listing of insured practitioner services. It contains the General Rules, Procedure List, Price List and Fee Modifier Definitions sections.

Service provider
(See Health service provider.)

Service recipient
A person who receives health services (the patient).

Skill
A practitioner's ability or proficiency, such as a specialty or a certification, which is recognized by a governing body and required in the provision of specific health services.

Specialty
A branch or area of study relating to a degree earned by a practitioner and recognized by a licensing body.

Stakeholder
A person or organization that provides or receives services or receives payment for services.

Statement of Account
A summary sent to practitioners that shows AHCIP benefit amounts paid on the associated Statement(s) of Assessment produced that week. Issued as notification of a direct deposit payment to a business arrangement. Also, a statement sent to direct-billed Alberta residents to detail amounts paid for insured services received.

Statement of Assessment
A weekly report to practitioners detailing the assessment results of each claim submission. Displays an explanatory code for any benefit amount that was reduced, refused or paid at zero.

Statement of Benefits Paid
A printed statement of practitioner and associated benefits paid by the AHCIP on behalf of a patient during a specified period, excluding any confidential claims.

Submitter
(See Accredited submitter.)

ULI
Unique Lifetime Identifier. (See PHN.)

Unlisted procedure
A procedure that does not have a HSC listed in the Schedule of Benefits. The practitioner submits under code 99.09, adding the appropriate alpha character for the body system involved, as well as supporting text and a claimed amount.

V (Varies)
The AHCIP computer term for how a payment rate for a HSC changes. Example: A dentist's consultation fee varies (is paid at a different rate) as compared with that of an oral surgeon.