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Alberta Health

Allied Health Practitioner's Resource Guide

Superseded

November 2017

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

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.

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Introduction

The purpose of this guide is to help allied health practitioners (dental surgeons, optometrists, podiatrists) 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:

- 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 on the Alberta Health website at http://www.health.alberta.ca/professionals/allied-services-schedule.html.

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

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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 handles 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

Practitioners may submit claims to the AHCIP for insured services provided to eligible Alberta residents (See 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.

1.2 Services Not Claimable from the AHCIP

- Services that are not insured may not be claimed from the AHCIP.
- 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 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) are not to be submitted to the AHCIP. They should be submitted directly to the WCB. (See Section 4.5 - Workers' Compensation Board (WCB) Claims.)

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1.3 Registering as a New Practitioner

A practitioner registering with Alberta Health for the first time must complete a Practitioner Information form - AHC0912. 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.

1.4 Practitioner Information Form (AHC0912) – Instructions for Completing

Section A: **New practitioner registration** – Complete as applicable.

Note: If you are a **salaried or contract 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. Complete sections A, B, D and H of the Practitioner Information form, and be sure to attach all required documentation. No other forms are required.

Section B: **Identification** – Complete all areas.

Section C: **Organization information** – Complete this section if you want to set up a business arrangement in a name other than your own, such as a professional corporation or clinic. Payments will be directed to the corporation/clinic. If you are a professional corporation, you will need to attach a copy of the Certificate of Incorporation as provided by your licensing body.

Section D: **Education, professional association registration and specialties/ certifications** – Complete all applicable areas. Be sure to attach the applicable documentation such as a copy of your practice permit from an Alberta licencing body, specialties, College/Association specialty certification letter, etc.

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Section E: **Business arrangement information** – Complete this section to indicate if you want a business arrangement in your own name, or in the name indicated in Section C. (See Section 1.7 - The Business Arrangement for more information.)

Section F: **Business arrangement/service provider relationship** – Complete this section if you are joining someone else's practice and will be billing through their business arrangement number. Both you and the business arrangement contract holder must sign this section.

Important

Note: If you are joining someone else's practice and/or assigning your payments to them be aware that your payment information (i.e., Statement of Assessment and Statement of Account) will be sent to the payee.

Section G: **Facility and functional centre information** – Complete this section if the physical location where you practise does not already have a facility number. Alberta Health can assist you in determining whether a new facility number is required.

Section H: **Authorization** – The physician must sign and date this section before this form is considered valid.

The Practitioner Information Form is available online at: www.health.alberta.ca/professionals/resources.html.

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1.5 Practitioner Information Form (AHC0912) - Sample

Alberta Government

Practitioner Information

Alberta Health
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AHW office use only

Alberta Health registers practitioners for claim payment or patient referral purposes. Please refer to page 3 of this form for a glossary of terms.

Section A - New practitioner registration

Register me as a ☐ Practitioner ☐ Referral Practitioner ☐ also register my Professional Corporation (PC)

Section B - Identification

Have you ever been registered with Alberta Health? ☐ Yes ☐ No

Provide your Personal Health Number
OR
Provide your out-of-province health number *(if applicable)* Province

Last name	First name	Middle name

Gender ☐ Male ☐ Female | Date of birth Year Month Day

Business mailing address		Residence mailing address	
City/Town	Province	City/Town	Province
Country	Postal code	Country	Postal code
Phone number		Phone number	
Fax number		Fax number	

Complete only if registering a new Professional Corporation or new clinic. If registering a Professional Corporation, you must attach a copy of the Certificate of Incorporation provided by your licensing body.

Section C - Organization information

Organization name

Business mailing address
☐ Same as business mailing address in **Section B** or

City/Town	Province	Country	Postal code
Phone number		Fax number	

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A copy of your practice permit/licence from your licensing body must be attached. Physicians must attach a copy of their Registration Understanding and Acknowledgement document outlining the terms and conditions, if applicable.

Section D - Education, professional association registration and specialties/certifications

Degree granted	Graduation date (Year Month Day)	Institution name	Province/ State	Country

College or association registered with

Date registered (Year Month Day) Licence number

Specialties and certifications obtained *(recognized in Alberta)* – **(A copy of your College/Association specialty letter must be attached.)**
(If more space is required, attach an additional page.)

Year Month Day

Year Month Day

Section E - Business arrangement (BA) information (see glossary)

BA effective date (Year Month Day) ☐ Fee for service ☐ Locum – medical only ☐ Alternate Relationship Plan (ARP)

Direct deposit ☐ Chequing – **attach a void cheque**
or ☐ Savings – attach documentation from financial institution indicating bank, branch transit, and account number

Make payment to ☐ Me or ☐ My PC/clinic or name
Identifier

Send Statement of Assessment and Statement of Account to ☐ Me or ☐ My PC/clinic or name
Identifier

The Accredited Submitter for this BA is *(name and submitter prefix)*

Indicate which skill will be used on most claims

Section F - Business arrangement/service provider (BA/SP) relationship (see glossary)

Complete this section only if you are joining an existing BA.

Effective (Year Month Day) I will be joining BA Number –

Indicate which skill will be used on most claims

"I, the Practitioner, assign to the Business Arrangement whatever benefits may be payable to me, from the Alberta Health Care Insurance Plan. This is in respect to claims I may make and for which I may be entitled, under this Business Agreement. I understand that benefits may be reassessed (increased or decreased) under the *Alberta Health Care Insurance Act*, including claims made prior to and during this assignment."

Practitioner signature Phone number

BA contract holder signature/ARP authorized representative signature Phone number

BA contract holder name and position/title/ARP authorized representative name Date

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Section G - Facility and functional centre information

Do not complete this section if you are practising in association with others and the facility has already been registered.

☐ New facility number effective   Year | Month | Day

Facility name

Facility physical address *(Provide a street address or a legal land description only. A post office box number is not a facility physical site address.)*

City/Town	Province	Postal code

Indicate the functional centre(s) in your facility

(Functional centres marked* require a copy of the College of Physicians and Surgeons of Alberta Accreditation Letter.)

☐ Examination room (Practitioner's office)
☐ Clinical lab*
☐ Diagnostic imaging*
☐ Non-hospital surgical suite*
☐ Other diagnostic lab*
☐ Electrodiagnosis*
☐ Radiology oncology*

Section H - Authorization (This section must be completed before this form is considered valid.)

Practitioner's signature ______________________ Date ______________________

Return completed forms to the Professional and Facility Management Unit at the address on page 1, or fax to 780-422-3552. If you have any questions, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address on page 1, or at the telephone or fax number provided above.

Glossary of Terms

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

Alternate Relationship Plan: A mechanism to remunerate practitioners in a manner other than the traditional fee-for-service method.

Business Arrangement: An agreement with Alberta Health to establish the arrangement for the payment of health services provided. All practitioners registered with Alberta Health must have or be part of a business arrangement in order to claim for services.

Contract Holder: A person, organization, or professional corporation entering into a business arrangement with Alberta Health.

Registration Understanding and Acknowledgement: A document provided by the College of Physicians and Sugeons which contains details on the terms and conditions of practice for the physician.

Statement of Account: A statement outlining the amount Alberta Health has released for payment based upon the claims assessed. Production of the statement is timed with the weekly payment cycle.

Statement of Assessment: A statement detailing the assessment result of each claim submitted. Claims reduced, refused, or paid at zero will have an explanatory code.

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1.6 Other Forms a Practitioner May Need to Complete

A 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, or if you are moving to a new site that is not yet registered with Alberta Health.
Organization Information: AHC0911	To register a professional corporation or clinic.
Business Arrangement Request: AHC0913	To set up a new business arrangement, change information on an existing business arrangement, or end an existing business arrangement.
Business Arrangement/Service Provider Relationship: AHC0914	To be added to an existing business arrangement, or to change information about your relationship with an existing business arrangement.
Direct Deposit Request: AHC1143	To change the direct deposit banking information for your claim payments.
H-Link Application for Submitter Role: AHC2210	To apply to be your own submitter.
Submitter/Client Relationship for Electronic Claim Submission: AHC2096	To authorize an accredited submitter to submit claims on your behalf, or to change from one submitter to another.

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Note: 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 address.

Following are samples of the various forms a 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 print them from our website at www.health.alberta.ca/professionals/resources.html.

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1.6.1 Facility Registration (AHC0910A) – Sample

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Alberta Government

Facility Registration
Delivery Site Registry

Alberta Health
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AH office use only

DSR#	DID#

Facility numbers are not transferable to another location; they are assigned to a physical site address.

Section A - Add/Change/End a Facility

Add a new facility	Change to an existing facility	End an existing facility
Effective Date (Year, Month, Day)	Effective Date (Year, Month, Day)	Effective Date (Year, Month, Day)
	Facility Number	Facility Number

If you are leaving this facility, will others continue to practice there? ☐ Yes ☐ No

Delivery site type: ☐ Practitioner office

Section B - Facility Identification

Facility common name

Organization name (Legal name registered with Alberta Corporate Registry)

Practitioner's name (only one required) | Practitioner ID

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

Facility physical address *(Provide a street address or a legal land description only. A post office box number is not a facility physical site address.)*

City/Town/Municipality	Province	Country	Postal Code

☐ Yes change my business mailing address to that above.

Facility (Delivery Site) communications

Business phone number	Business fax number	Business email

Indicate the functional centre(s) in your facility
(Functional centres marked* require a copy of the College of Physicians and Surgeons of Alberta Accreditation Letter.)

☐ Examination room (Practitioner's office) ☐ Clinical lab* ☐ Other diagnostic lab* ☐ Radiology oncology*
☐ Diagnostic imaging* ☐ Electrodiagnosis* ☐ Non-hospital surgical suite*

Section C - Authorization (This section must be completed before this form is considered valid.)

Name and position/title

Date *(yyyy-mm-dd)* Signature

Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.

AHC0910A (2014/11) Reset Form Save Form Print Form Page 1 of 1

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1.6.2 Organization Information (AHC0911) – Sample

Alberta Government — **Organization Information**

Alberta Health
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AHW office use only

An organization is established when payment from Alberta Health is to be made to someone other than the practitioner, i.e. a Professional Corporation or a Clinic.

If you are registering a Professional Corporation, you must attach a copy of the Certificate of Incorporation as provided by your licensing body. Medical practitioners must send Form 'F' from the College of Physicians and Surgeons of Alberta.

Section A - Identification, type and date of change

Organization Name ______

Effective Year | Month | Day

☐ Create a new organization

Practitioner identifier ____ - ____

☐ Change the organization information (show changes in section B)

☐ End the organization

Professional corporation or clinic ULI ____ - ____ *(for change or end)*

Section B - Organization information

Business mailing address		
City/Town	Province	Postal code

Section C - Authorization (This section must be completed before this form is considered valid.)

Signature	Phone number
Name and position/title	Date

Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.

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1.6.3 Business Arrangement Request (AHC0913) – Sample

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Alberta Government

Business Arrangement (BA) Request

Alberta Health
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AHW office use only

A business arrangement (BA) is an agreement with Alberta Health to establish the arrangement for payment of health services provided. All practitioners registered with Alberta Health must have or be part of a BA in order to claim for services. A contract holder is a person, organization or professional corporation (PC) entering into a business arrangement with Alberta Health.

Section A - Identification, type and date of change

The business arrangement contract holder is:

Practitioner identifier ______ - ______

or

PC or clinic ULI ______ - ______

Name ______

Effective Year ____ Month __ Day __

☐ Assign a new BA ☐ Change information on an existing BA ☐ End a BA

Business arrangement number to change or end ______ - ____

Section B - Business arrangement information

Business arrangement type ☐ Fee for service ☐ Locum – medical only ☐ Alternate Relationship Plan (ARP) ☐ Family Care Clinics (FCC)

Direct deposit to ☐ Chequing – **attach a void cheque**
or ☐ Savings – attach documentation from financial institution indicating bank, branch transit, and account number

Make payment to ☐ Me or ☐ My PC/clinic or name ______
Identifier ______

Send Statement of Assessment and Statement of Account to ☐ Me or ☐ My PC/clinic or name ______
Identifier ______

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

The Accredited Submitter for this BA is *(name and submitter prefix)* ______

Suppress Statement of Assessment production ☐ Yes ☐ No

(If your accredited submitter provides this information, it may not be necessary to receive it from Alberta Health.)

Indicate the skill that will be used on most claims ______

Section C - Authorization (This section must be completed before this form is considered valid.)

Practitioner's signature ______ Phone number ______

BA contract holder signature/ARP authorized representative signature ______ Phone number ______

BA contract holder name and position/title/ARP authorized representative name ______ Date ______

Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.

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1.6.4 Business Arrangement/Service Provider Relationship (AHC0914) – Sample

Alberta Government

Business Arrangement (BA)/ Service Provider (SP) Relationship

Alberta Health
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AHW office use only

A Business Arrangement to Service Provider Relationship form is used to add or change information on the relationship. A default skill (see section A) is the primary skill used by the practitioner. Practitioners with multiple skills can designate a default skill. When the skill field on a claim is left blank, the claim is automatically processed using the default skill. A Contract Holder (see section A and B) is a person, organization or professional corporation entering into a business arrangement with Alberta Health.

Section A - Type and Date of Change

	Business Arrangement number	Effective date (Year / Month / Day)
☐ Add me to the Business Arrangement (BA)		
☐ Change my start date with this BA		
☐ Change my BA default skill to ______		
☐ End my relationship with the BA		

BA Contract Holder Name ______

Practitioner Name ______ Practitioner ID

Indicate the skill that will be used on most claims ______

Section B - Authorization (This section must be completed before this form is considered valid.)

"I, the Practitioner, assign to the Business Arrangement whatever benefits may be payable to me, from the Alberta Health Care Insurance Plan. This is in respect to claims I may make and for which I may be entitled, under this Business Agreement. I understand that benefits may be reassessed (increased or decreased) under the *Alberta Health Care Insurance Act*, including claims made prior to and during this assignment."

Practitioner's signature ______ Phone number ______

BA contract holder signature/ARP authorized representative signature ______ Phone number ______

BA contract holder name and position/title/ARP authorized representative name ______ Date ______

Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522, or toll free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.

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1.6.5 Direct Deposit Request (AHC1143) – Sample

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Alberta Government

Direct Deposit Request

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 toll-free within Alberta at 310-000 then 780-422-1522 or by mail at Alberta Health, Claims Management Unit, PO Box 1360 Stn Main, Edmonton AB, T5J 2N3.

For AH Office Use Only

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:

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

Professional Corporation or Clinic Name:

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.

Bank Address | City/Town

Bank Transit/Branch Number | Bank Number | Account Number

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 | 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:

BA Contract Holder Authorization *(This section must be completed)*

I, the Business Arrangement Contract Holder, verify that the information provided in this form is correct and that I am able to authorize the changes identified above regarding banking information for the business arrangements 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)*: | BA Contract holder/ARP Authorized Representative Signature:

Send completed forms to the Professional and Facility Management Unit via fax to 780-422-3552 or via email to Health.PracForms@gov.ab.ca.

Refer to the instructions for help completing this form. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

AHC1143 (2017/06) Save Form Page 1 of 1

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1.6.6 H-Link Application for Submitter Role (AHC2210) – Sample

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Alberta Government

H-Link Application for Submitter Role

The information requested on this application is being collected by Alberta Health pursuant to section 20(b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the sole purpose of creating a Submitter Role. If you have questions regarding the collection of this information, please contact the H-Link Administrator at the address or fax number provided below.

****** Required fields are bold ******

For information on completing this form, see page 2.

Section A - Submitter Role		
Please check one of the following: ☐ Amend *(underline amendments)* ☐ Create ☐ Delete		Date *(yyyy-mm-dd)*
Name (practitioner or organization)		**Practitioner ID** *(if already assigned)*
Business phone number	Business fax number	Business email
Mailing address *(include city, province and postal code)*		
Physical address *(include city, province and postal code)*		
Section B - Technical Software Contact Information		
Name		
Business phone number	Business fax number	Business email

Section C - Submitter Agreement

I hereby authorize the creation, amendment or deletion of a Submitter Role.

I confirm that the above named Submitter is an affiliate of the Custodian (practitioner or organization named above) under the *Health Information Act*.

I confirm that I understand my obligations associated with the management of health information, including any actions taken by the Submitter as my affiliate, as outlined in the *Health Information Act*.

I confirm that I have read and will comply with the Alberta Health Electronic Claims Specification (H-Link) Manual.
I understand the manual may be amended from time to time at the sole discretion of Alberta Health.

Last name	**First name**	Middle name
Business phone number	**Date** *(yyyy-mm-dd)*	**Signature**

Section D - Accreditation (Alberta Health)	
Authorized by	Signature
Submitter prefix code	Date *(yyyy-mm-dd)*

Note: To obtain access to H-Link, the following forms must also be completed:
AHC2208 - Access Administrator Application, Agreement and Authorization
AHC2209 - External User ID Application Access Request

Mail or fax the completed forms to: Alberta Health
Attention: H-Link Administrator
PO Box 1360 Stn Main
Edmonton, AB T5J 2N3

Fax: 780-422-7248

AHC2210 (2016/04) Save Form Print Form Page 1

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1.6.7 Submitter/Client Relationship for Electronic Claim Submission (AHC2096) – Sample

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Government of Alberta

Submitter/Client Relationship for Electronic Claim Submission

Alberta Health and Wellness
Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton AB T5J 2N3

For AHW office use only

Business Arrangement contract holder

Name ____________

Business address ____________

Practitioner identifier (PRAC ID) or BA contract holder ULI ____________

Proposed commencement date ____________

Contact name ____________

Contact phone number ____________

*BA number(s) ____________

***Note:** (1) If there is more than one practitioner registered on the BA, only the BA contract holder's signature is required. We do not require a form from each practitioner on the BA.
(2) If adding a practitioner to a BA, this form is not required.

Submitter

Name ____________

ULI number ____________

Submitter prefix code ____________

Proposed submission date ____________

Contract holder certification and agreement

I hereby authorize this accredited submitter to submit my claims electronically on my behalf. I further certify that my agreement with the accredited submitter, who is party to this application, conforms fully to the Electronic Claims Submission Specifications Manual and the *Alberta Health Care Insurance Act* and Regulations and that I am fully responsible for the correctness and security of all information submitted to obtain payment of claims.

Signature(s) ____________

Name(s) ____________

Date ____________

Submitter certification and agreement

I hereby certify that my agreement with the contract holder, who is party to this application, conforms fully to the Electronic Claims Submission Specifications Manual.

Signature(s) ____________

Name(s) ____________

Date ____________

Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.

Information collected is used to enrol you for programs or benefits funded by Alberta Health and Wellness. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. 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 questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.

AHC2096 (2010/04)

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1.7 The Business Arrangement

To submit claims for insured services, a 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. A practitioner registering with Alberta Health for the first time provides their business arrangement details when they complete section E on the Practitioner Information form - AHC0912.

A practitioner may have more than one business arrangement, and a business arrangement may have more than one participating physician. All physicians participating in the same business arrangement must be linked to that business arrangement in order to claim for insured services.

Note: If a 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.

To make a change to an existing business arrangement or to request a new business arrangement, complete a Business Arrangement Request form - AHC0913. (See Section 1.6.3 for a sample of this form.) If your business arrangement is no longer in use, please contact Alberta Health at 780-422-1522.

1.7.1 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 forms:

- Organization Information - AHC0911. Attach a copy of the Certificate of Incorporation as provided by your licensing body.
- Business Arrangement Request - AHC0913.
- If applicable, Business Arrangement/Service Provider Relationship - AHC0914. This identifies any other practitioner (s) who will also be billing through the business arrangement number (e.g., a clinic).

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1.7.2 The business arrangement and the practitioner's default skill

The default skill is the **most appropriate skill** used by the practitioner 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 section E on the Practitioner Information form - AHC0912.
- As applicable, practitioners completing the Business Arrangement Request - AHC0913 and Business Arrangement (BA)/Service Provider (SP) Relationship -AHC0914 forms 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.

1.7.3 The business arrangement and direct deposit

Payments to 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 practitioner is setting up a new business arrangement, they provide their direct deposit details in section E on the Practitioner Information form - AHC0912.
- When a 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 Request form - AHC0913.
- When a new practitioner is joining an existing business arrangement (section F on the AHC0912 form), the direct deposit provision already established for that business arrangement applies.
- A registered practitioner who wishes to 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.

Note: Completed forms and void cheques can be faxed to 780-422-3552; 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.

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1.7.4 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 in order for claims to be submitted for payment.

If you are a new 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 Submitter/Client Relationship for Electronic Claim Submission form - AHC2096.
  - 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 780-644-7463 when prompted. You can also send an email to health.hlink@gov.ab.ca

Note: 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

1.8 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.).

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.

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1.9 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 780-422-1522 or fax the completed Facility Registration/Delivery Site Registry form - AHC0910A to Alberta Health at 780-422-3552.

1.10 Mandatory Address Reporting

Alberta Health must be notified in advance of any changes to your business mailing address. You may do this by faxing a letter signed by the Contract Holder (please include the PRAC ID) to 780-422-3552. The Contract Holder is the person, organization or Professional Corporation that entered into a business arrangement with Alberta Health.

1.11 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:

Organization Information: AHC0911	To identify the name of the clinic or professional corporation.
Business Arrangement Request: AHC0913	To set up a new business arrangement.
Business Arrangement/Service Provider Relationship: AHC0914	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.

If you need more information about Alberta Health requirements when purchasing an existing practice, call the Provider Relationship and Claims unit at 780-422-1522, or toll-free 310-0000 then 780-422-1522 when prompted.

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2.0 Patient Basics - Eligibility

2.1 Alberta Residents

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

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 – they are who they claim to be.
- Legal entitlement to be in Canada – they have the authority set out under Canadian federal law to be in Canada.
- Alberta residency – prove that they reside in Alberta and meet the definition of a resident.

Note: 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.

To help reduce the number of claims refused due to problems with a patient's eligibility for benefits, always verify that your patient has AHCIP coverage. Alberta Health provides a 24-hour interactive telephone inquiry service that enables practitioners and their staff to check a patient's eligibility for coverage and validity of their Personal Health Number (See Section 2.3 – The Interactive Voice Response (IVR) System.)

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2.2 Patients who are Eligible

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.

Note: If there has been an address change or a replacement card is needed, please tell the patient they must call Alberta Health to advise 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 www.health.alberta.ca/AHCIP/registration-locations.html.

Alternatively, practitioner offices can have Patient Information Update forms available for change requests. These forms can be faxed to Alberta Health directly. The form can be found on the Alberta Health Website at: http://www.health.alberta.ca/documents/AHCIP-Form-AHC2148.pdf.

If a patient presents an Alberta personal health card but provides an out-of-province address, call our 24-hour interactive telephone inquiry service. Confirmation of the patient's eligibility is needed prior to submitting a claim to the AHCIP.

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2.3 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 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 calling the Health Insurance Programs Branch at 780-422-1600 (toll-free 310-0000 then enter 780-422-1600) and arranging for a "limits" letter to be sent to the patient.

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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.

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

2.4 Patients who are not Eligible

The following individuals living in Alberta are **not eligible** for AHCIP coverage:

- Those who have active health coverage in another province. (Persons who have moved to Alberta recently and are still covered under the health plan of another province/territory or are just working in Alberta temporarily.)
- Those who have chosen to formally opt out of the AHCIP.
- Those who have not yet registered with Alberta Health.
- Those who present a health care card that is not active (confirmed by IVR).

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- Temporary residents such as foreign workers, students and their dependents' who present an Alberta health care card with a past expiry date, who have not applied for a 90 day extension.
- Canadian Forces personnel and federal penitentiary inmates. These individuals are covered by the federal government and their health cards are different. Services provided to patients in this category should be billed directly to the federal government or other secondary insurer, as applicable.

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

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2.5 Patients without an Alberta Personal Health Card

If your patient claims to be registered with the AHCIP but does not provide an Alberta personal health card or number, call our Registration Research telephone number. Our staff will search for a patient's personal health number (up to three PHNs per call) while you wait on the phone. PHNs will only be released for a past or current service, so a claim can be processed.

- In Edmonton, call 780-415-2288.
- From outside Edmonton, call toll-free 310-0000 and then enter 780-415-2288 when prompted.

This service is available Monday to Friday from 8:15 a.m. until 4:30 p.m. except on holidays, and is for **exclusive** use of practitioner offices. Please **do not** give this number to the public, as it will affect our ability to provide prompt and efficient service to practitioner offices.

Note: 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.

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2.6 Patients who Opt Out

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.

2.7 Patients who do not have Active AHCIP Coverage

Bill the patient directly and, if applicable, provide the patient with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 to submit to their provincial/territorial health plan. This form is available on our website at www.health.alberta.ca/AHCIP/forms-claims.html.

Note: 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.

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2.8 Patient PHN Problems

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.
- If you cannot obtain a correct PHN, call our Registration Research unit (See Section 2.5 - Patients without an Alberta Personal Health Card.)
- Complete a Request for Personal Health Numbers form - AHC0406 and fax it to 780-415-1704. We will return the form to you with the research results. This form is not available online; to order a supply call our Registration Research unit.

2.9 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.

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.

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3.0 Claim Submission

If you/your billing staff prepare 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 person data, supporting text, and supporting text cross-reference segments in cases when this information needs to be attached to base claim segments. (See Section 3.4 – 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.

Note: 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.

3.1 Claim Basics

You will need the following information on a claim to the AHCIP:

WHO was involved:

Enter:

- The personal health number of the patient.
- 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 from the Schedule of Benefits Procedure List, plus any applicable modifier code(s) from the Price List.

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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 Claim Processing Timelines

Practitioners have 180 days from the date the health service was provided to submit a claim. If a claim is being resubmitted, it must be received within 180 days from the date of the last Statement of Assessment on which the claim appeared. A resubmitted claim is not payable if it is resubmitted more than 180 days after the last transaction for that claim (See Section 4.3 - Outdated Claims.)

Claims to the AHCIP are submitted electronically via H-Link. The weekly cut-off for claim submissions is **4:30 p.m. on Thursdays**. Claims submitted by Thursday of one week are processed for payment on Friday of the following week. Payments are made via electronic funds transfer (EFT).

Exceptions to this 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 Alberta Health website, notifications on H-Link, or by inserts placed in the Statement of Assessment.

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Note: 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.

3.3 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. (See Section 6.5 - 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) • 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.)

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- **Do not** use action code **C** to change any of these details:
  – patient's personal health number
  – practitioner 's 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
  – practitioner 's 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.

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3.4 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 3.4.1 through 3.4.4. Carefully completing the data fields within the segments helps ensure claim payments are prompt and correct.

Note: 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.

3.4.1 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:

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 physician 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.

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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 specialties 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 can 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. (See Section 3.4.2 - Claim Person Data Segment – CPD1.)
- Once the PHN appears on the Statement of Assessment, enter it on any subsequent claims.

Health Service Code:

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

- **Reminder to dentists and podiatrists**: Procedures claimed under section 99.09 (Procedures not elsewhere classified) require supporting text/documentation (See Section 3.7 – Submitting Claims for Unlisted Procedures.)
- It is **not** appropriate to submit a claim using a code from the 99.09 section when a specific health service code 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 health service code that is similar to the actual procedure performed.

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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 180 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 health service code.

Diagnostic Code: 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.

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Note: 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 health service code 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 health service code, or the number of units for time-based services.
- If the number of services you provided exceeds the maximum specified for that health service code, 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. (See Section 3.6 - 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., physician'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.

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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. (See 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.

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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 provider.

- 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.

- 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. (See Section 4.1 - Alberta's Good Faith Policy.)

- 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)

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- 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.

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 here.

3.4.2 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., good faith claim – see Section 4.1 - Alberta's Good Faith Policy).
- A newborn patient without a PHN. (See 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.

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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.

3.4.3 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.

You may want to check with your accredited submitter regarding the data requirements of the claim supporting text segment.

3.4.4 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.

3.5 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
1. a first-time claim for a newborn:	✔ newborn code ✔ person data segment (including parent/guardian PHN)
2. good faith:	✔ good faith indicator (enter Y) ✔ person data segment
3. pay-to code OTHR:	✔ pay-to PHN field **or** person data segment
4. out-of-province referral:	✔ out-of-province referral indicator ✔ person data segment

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3.6 Modifier Codes

Modifier codes influence the payment of claims. They can add or subtract an amount from the base rate of a health service code, 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 health service code.

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:

- **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.)

- **Lesser value procedure** – Indicates 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:

- **Number of services** – Derived from data in the Calls field.
- **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.

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3.7 Submitting Claims for Unlisted Procedures

The 99.09 section of the Schedule of Benefits contains the health service codes for unlisted procedures. When you provide a service that is not listed in the Schedule, either as a single item or a combination of items, you may be able to use the applicable unlisted procedures code on your claim submission.

1. Determine if the service is insured under the Alberta Health Care Insurance Plan (AHCIP).

2. Review the Schedule to determine if a health service code 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 health service code(s) for the service, submit the claim accordingly.

3. If you cannot identify an appropriate health service code, submit your claim using the appropriate code from the 99.09 section of the Schedule.

4. When preparing a claim for an unlisted procedure, determine an equivalent or comparable service listed in the Schedule in terms of time, complexity and intensity. Provide supporting information, such as an operative report or descriptive text. Include equivalencies, the service description, time and the amount claimed.

Alberta Health assesses claims for unlisted services by comparing the service provided and the fee claimed with similar or comparable services listed in the Schedule. The assessment will be based on information concerning the time, complexity and intensity of the service, as provided on the text in your claim or, if applicable, the submitted operative report. Claims for unlisted procedures may require more time-consuming manual assessment.

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

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4.0 Special Situations

4.1 Alberta's Good Faith Policy

The good faith policy was developed to minimize 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.

As the good faith policy is **not open-ended**, it is important that practitioners/their staff, after questioning the patient, are confident that:

1. The patient is a permanent Alberta resident and eligible for AHCIP coverage, and
2. The patient is who they say they are. Patients **must** present two pieces of original identification, including at least one that includes a photo and at least one that displays their current Alberta address.

A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes his/her home and is ordinarily present in Alberta. This definition **does not include** tourists, transients or visitors to Alberta.

Note: Canadian Forces personnel, persons incarcerated in federal corrections facilities, and residents of other provinces or countries are **not eligible** for AHCIP coverage and **do not qualify** for payment of claims under the good faith policy. Good faith claims submitted for these patients will be refused.

To help determine if a patient has or is eligible for AHCIP coverage, please refer to Section 2.0 – Patient Basics – Eligibility.

To qualify for processing under the good faith policy, good faith claims must be received at Alberta Health **within 30 days from the date of service**. If all criteria for a good faith submission are met, the initial claim for the patient may qualify for good faith processing. Subsequent services provided to the same patient by another practitioner using the same business arrangement number must be submitted to Alberta Health within seven days after the initial good faith claim was submitted in order to be considered for payment.

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On your good faith claim:

- Enter Y in the Good Faith Indicator field in the base claim segment. (See Section 3.4.1 - In-Province Provider Base Claim Segment – CIB1.)
- Attach a person data segment and enter the personal information collected from the patient, including their name and permanent Alberta address. (See Section 3.4.2 - Claim Person Data Segment – CPD1.)

The patient information on the good faith claim will be used by our staff to determine whether coverage exists for the patient. If investigation reveals that a patient is **not** eligible for AHCIP coverage, you will be notified on a negative Statement of Assessment with the applicable explanatory code.

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)

Note: 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.

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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 Outdated Claims

If you wish to submit an outdated claim for which you believe extenuating circumstances apply, you must first send a written request to Alberta Health to the attention of the Claims Management unit.

Extenuating circumstances apply in very few cases. For example, consideration may be given to outdated claims resulting from a disaster (fire, flood), fraud, theft of computer or paper records, or claims refused by the Workers' Compensation Board.

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

- A claim to the AHCIP is not payable if it is received at Alberta Health more than 180 days after the date the health service was provided or the patient was discharged from hospital.
- A resubmitted claim is not payable if it is resubmitted more than 180 days after the last transaction for that claim.

Describe the extenuating circumstance and include the number of claims involved, the specific dates, and the dollar values. Your request will be considered and a written reply provided, including resubmission instructions, if applicable.

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.

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 are 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

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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 and the WCB online remittance must accompany the claim** and can be faxed to 780-422-1958.

Note: 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).

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 regarding the WCB visit www.wcb.ab.ca.

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 3.3 – Action Codes.

Note: Alberta Health regularly reviews practitioner claims to identify and recover funds where practitioners received payment for treatment of a patient's work-related injury/condition from both Alberta Health and the WCB, and where practitioners 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.

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Note: Do not submit WCB claims to Alberta Health as good faith claims. Doing so will create a lengthy administrative process for your office to correct this submission.

4.6 RCMP Member Claims

Effective April 1, 2013, members of the Royal Canadian Mounted Police (RCMP) who are residents of Alberta are eligible for coverage under the Alberta Health Care Insurance Plan (AHCIP). This change is the result of an amendment to the *Canada Health Act*.

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 practitioner'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.

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

4.7 Health Care Services Provided Outside Canada

There are two sources of funding for medical treatment outside Canada.

1. Partial reimbursement through the AHCIP.

   The AHCIP provides **limited coverage** for insured medical, oral surgical and hospital services obtained outside Canada in an emergency situation.

   Further information regarding coverage outside Canada can be found on the Alberta Health website at www.health.alberta.ca/AHCIP/coverage-outside-Canada.html.

   Further information on how an Albertan can submit a claim for reimbursement can be found at www.health.alberta.ca/AHCIP/submitting-claims.html

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2. Application for prior approval through the Out-of-Country Health Services Committee (OOCHSC)

   The Out-of-Country Health Services Committee (OOCHSC) considers applications for funding of insured medical, oral surgical and/or hospital services that are not available in Canada and operates at arms-length from Alberta Health.

   Applications to the OOCHSC must be submitted by an Alberta physician or dentist on behalf of a resident. Applications for funding for elective health services must be submitted prior to the service being received. Services that are experimental or fall under the category of applied research are not eligible for funding.

   Applications for out-of-country funding must be made in writing and directed to:

   Chair, Out-of-Country Health Services Committee
   PO Box 1360 Station Main
   Edmonton AB T5J 2N3
   FAX: 780-415-0963

   Information about the OOCHSC is available by calling 780-415-8744 in Edmonton, or toll-free by dialling 310-0000, then 780-415-8744 when prompted.

   Additional information can be found on the Alberta Health website at: http://www.health.alberta.ca/AHCIP/out-of-country-health-services.html

Note: Submitting a request for funding to the OOCHSC **does not guarantee approval**. When making decisions, the OOCHSC is required to follow the criteria set out in the *Out-of-Country Health Services Regulation* which can be found online at www.health.alberta.ca/about/health-legislation.html.

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Funding applications that have been denied by the OOCHSC can be appealed to the Out-of-Country Health Services Appeal Panel. Appeals may be submitted by the Alberta physician or dentist 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. In addition to medical experts, the Appeal Panel includes a member of the general public and an ethicist.

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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

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5.0 Out-of-Province Patients

5.1 Practitioner Billing

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

1. Complete an Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. Submit the claim to the patient's home province or territory for payment consideration. For Quebec patients, please complete a Quebec Claim for Physician/Practitioner Services form found on the Alberta Health website.

Note: The Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 is available on our website at www.health.alberta.ca/AHCIP/forms-claims.html. Please ensure that all applicable information about the service is completed on the form.

2. Bill the patient directly. Provide them with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. The patient may submit the claim to their home province health plan for reimbursement. A copy should be retained in the practitioner's office as a record of payment.

Note: 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.

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5.2 Out-of-Province Claim for Physician/Practitioner Services Form (AHC0693) - Sample

Superseded

OUT-OF-PROVINCE CLAIM FOR PHYSICIAN/ PRACTITIONER SERVICES

SPACE PROVIDED FOR ADMINISTRATIVE PURPOSES

A To be completed by Patient or Parent / Guardian of Patient *(please type or print clearly)*

PATIENT'S SURNAME ON HEALTH CARD | FIRST NAME | INITIALS | HEALTH CARE NUMBER

PERMANENT MAILING ADDRESS | DATE OF EXPIRY

CITY | PROVINCE/TERRITORY | POSTAL CODE

BIRTHDATE YEAR MONTH DAY | SEX ☐ M ☐ F | NAME OF PARENT / GUARDIAN | RELATIONSHIP TO PATIENT

DATE OF DEPARTURE FROM HOME YEAR MONTH DAY | PLACE WHERE TREATED (PROVINCE, TERRITORY) | DATE OF ARRIVAL YEAR MONTH DAY | IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | IF NO, SPECIFY DATE OF RETURN HOME YEAR MONTH DAY

GIVE REASON FOR ABSENCE FROM HOME: ☐ VACATION ☐ STUDY NAME OF INSTITUTION ☐ BUSINESS ☐ OTHER PLEASE SPECIFY

B Declaration of Patient or Parent / Guardian of Patient

I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the Canada Evidence Act, that the information given above is correct and that I am a beneficiary of the Medical Care Plan in the province/territory of ____.

I request that payment be made: directly to the physician/practitioner ☐ to patient/contract holder ☐

SIGNATURE OF PATIENT (if other than patient, state relationship to patient) | DATE | TELEPHONE NO. (Home) AREA CODE ( ) | TELEPHONE NO. (Work) AREA CODE ( ) EXT.

C To be completed by Physician / Practitioner *(please type or print clearly)*

PHYSICIAN'S/PRACTITIONER'S NAME AND INITIALS | SPECIALTY ☐ CERTIFIED ☐ NON-CERTIFIED

ADDRESS | CHECK HERE IF: ☐ ANAESTHETIST ☐ SURGICAL ASSISTANT ☐ PSYCHIATRIST | PROVIDE DURATION OF SERVICE HRS MINS

NAME OF REFERRING PHYSICIAN/PRACTITIONER (IF APPLICABLE) | SPECIALTY

POSTAL CODE | SERVICES PROVIDED IN: ☐ OFFICE ☐ HOME ☐ HOSPITAL OUT-PATIENT ☐ HOSPITAL IN-PATIENT

IF HOSPITAL SERVICES, PLEASE PROVIDE: NAME OF HOSPITAL, ADDRESS | ADMISSION DATE YEAR MONTH DAY | DISCHARGE DATE YEAR MONTH DAY

IF CLAIMING IN-PATIENT CARE, PLEASE INDICATE SERVICE DATES

SERVICE DATE(S)	YEAR	MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PROCEDURE/TREATMENT	FEE CODE	FEE	DATE OF SERVICE (YEAR MONTH DAY)	TIME	FOR OFFICE USE ONLY

DIAGNOSIS AND OTHER REMARKS

CLAIM INVOLVES: ☐ WORKERS' COMPENSATION ☐ PENSIONABLE DISABILITY ☐ AUTOMOBILE ACCIDENT ☐ OTHER THIRD PARTY

☐ PAY PHYSICIAN/PRACTITIONER I accept the patient's plan payment as payment in full ☐ PAY PATIENT ☐ OTHER (SPECIFY) ____________

PHYSICIAN'S/PRACTITIONER'S SIGNATURE | DATE | LANGUAGE OF CORRESPONDENCE ☐ ENGLISH ☐ FRENCH

AHC0693 (2005/01)

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5.3 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.

Note: 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 or clinics with patient's out-of-province health care numbers. Refer to Section 5.1 for billing options if a valid health insurance card is not presented.

Samples of all province/territory health cards are displayed in Appendix B. If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office to resolve any beneficiary entitlement concerns.

Superseded

5.4 Province/Territory Contact Information and Claim Submission Time Limits

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

Nova Scotia
Nova Scotia Medical Services Insurance (MSI)
General Inquiries: 902-496-7008
E-mail: MSI@medavie.ca
Website:
http://novascotia.ca/dhw/msi/contact.asp
Time limit: 3 months

Prince Edward Island
PEI Medicare
General Inquiry: 902-368-6414
Toll free (throughout Canada): 1-800-321-5492
Website:
http://www.gov.pe.ca/health/index.php3?number=1018473
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

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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/apply-ohip-and-get-health-card
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: www.manitoba.ca/health/mhsip
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: http://www.hss.gov.yk.ca/contactus.php
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:
http://gov.nu.ca/health/information/nunavut-health-care-plan
Time limit: 6 months

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6.0 Reviewing Claim Results

6.1 Tracking Your Claim

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.
- 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.

Claims pass through the automated claims processing system; however, claims that involve complex procedures may require more time-consuming manual assessment. Following is a brief description of the claim process:

- Prior to assessment, the system checks and validates mandatory fields for accurate data.
- The claim is then assessed in accordance with the 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. Either it will be found valid and processed for payment, applied at "$0" or it will be refused. In all cases, it will appear on your Statement of Assessment with a final assessment result.

6.2 Statement of Assessment

Once claims have been processed, Alberta Health prepares a Statement of Assessment and sends it to you weekly by mail or electronically via your 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 you keep track of your assessed claims.

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

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

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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**.

Note: 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 already receive a statement directly from your submitter and do not wish to receive the Alberta Health paper version, submit a written request to Alberta Health to have them suppressed.

If you are missing any Statement of Assessment within 30 weeks of the issue date, please contact your submitter for electronic assessment result details files. 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) (See Appendix A.3 – Obtaining Alberta Health Resource Material.)

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Note: Alberta Health will not provide copies of the Statement of Assessment outside 52 weeks of the date the Statement was issued, 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.

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6.3 Statement of Assessment - Sample

E400RS1

ALBERTA HEALTH
P.O. BOX 1360
Edmonton AB T5J 2N3

STATEMENT DATE: 2014/04/24 **4**
PAGE: 1

1
Dr. Andrew Boodek
#555, 55 Alberta Way
Anywhere AB T9T 9T9

STATEMENT OF ASSESSMENT

5 Reference Nbrs
146098100 876198100

Business Arrangement 9999-999 **2**
Expected Payment Date 2014/05/02 **3**

6 Sequence Nbr
01

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	**19** Exp Code	Exp Code	**20** Registration Number	**21** RC
7 Boodek, Andrew		**8** 1992-39000													
9 Banery, Marvin	39053 26D	**11** 72636-9000	ELA09BA00007930	2014/02/05	99.99A	0.00	21.54				APLY				
Lodger, Beatrice	39053 35D	72658-9000	ELA09BA00008045	2014/02/17	99.99A	0.00	48.28				APLY				
Chipmon, Steve	39053 39D	91450-9000	ELA09BA00008078	2014/02/05	99.99A	0.00	31.87				APLY				
Quastell, Loni	39053 21C	92730-9000	ELA09BA00008086	2014/02/12	99.99A	0.00	21.54				APLY				

22 Total Amount to be Paid 123.23

23 Total Amount (RVRSL) 0.00

Patient Name	Chart Number	PHN	Claim Number	Service Start Date	Service Code	Claimed Amount	Assessed Amount	Mod Code	Mod Code	Mod Code	Result Code	Exp Code	Exp Code	Registration Number	RC
7 Doggle, A.C.		**8** 6843-39000													
Parsill, Judy		23735-9000	ELA09BJ00008060	2014/03/26	99.99A	0.00	437.59	SAU			APLY				
Rutlatch, Craig		37735-9000	ELA09BJ00008045	2014/03/25	99.99A	0.00	78.24	SAU			APLY				
Owins, Ollie		92649-9000	ELA09BJ00018895	2014/03/01	99.99A	0.00	75.63	SAU			APLY				

Total Amount to be Paid 591.46

Total Amount (RVRSL) 0.00

24 Summary Total
----

25 Provider Name	**26** Assessed Amount
Boodek, Andrew	123.23
Doggle, A.C.	591.46
27 Total Amount to be Paid	714.69

*Note: Health Service Code 99.99A is not a valid code and is used for illustration purposes only.

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6.4 Statement of Assessment – Field Descriptions

To help you understand the Statement of Assessment, please refer to the sample in section 6.3. 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. **Practitioner**
   Name of the person 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 practitioner.
11. **PHN**
    Personal health number identifying each patient.
12. **Claim Number**
    Number assigned to each claim by the submitter.

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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 a health service code.
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**
    Not applicable to allied health practitioners.
21. **Recovery Code**
    Not applicable to allied health practitioners.
22. **Total Amount to be Paid**
    Total amount to be paid for services provided by practitioners in the business arrangement.
23. **Total Amount (RVRSL)**
    Total amount being recovered from the business arrangement, if payments for previous claims were adjusted.
24. **Summary Total**
    Summary of the amounts payable for services provided by each practitioner and a grand total amount payable to the business arrangement.
25. **Provider Name**
    Name of each practitioner in this business arrangement who had claims processed.
26. **Assessed Amount**
    Amount to be paid for each practitioner's services.
27. **Total Amount to be Paid**
    Total amount to be paid to the business arrangement.

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6.5 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 also 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. (See Sections 3.3 - Action Codes and 6.6 - 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 physician.

   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. (See Sections 3.3 - Action Codes and 6.6 - 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**.

Note: If the AHCIP makes a global claim reassessment due to a retroactive system change to a health service code, 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.

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6.6 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 health service code 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. • Use **action code A** (add). • 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. • Use **action code C** (change). • 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. • Use **action code R** (reassess). • Complete the supporting text segment with information to support your reassessment request. • A base claim segment is optional.

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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. • Use **action code D** (delete). • No base claim data is required.

6.7 Statement of Account

Superseded

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) (See Appendix A.3 – Obtaining Alberta Health Resource Material.)

Note: Alberta Health will not provide copies of the Statement of Account outside 52 weeks of the date the Statement was issued, 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.

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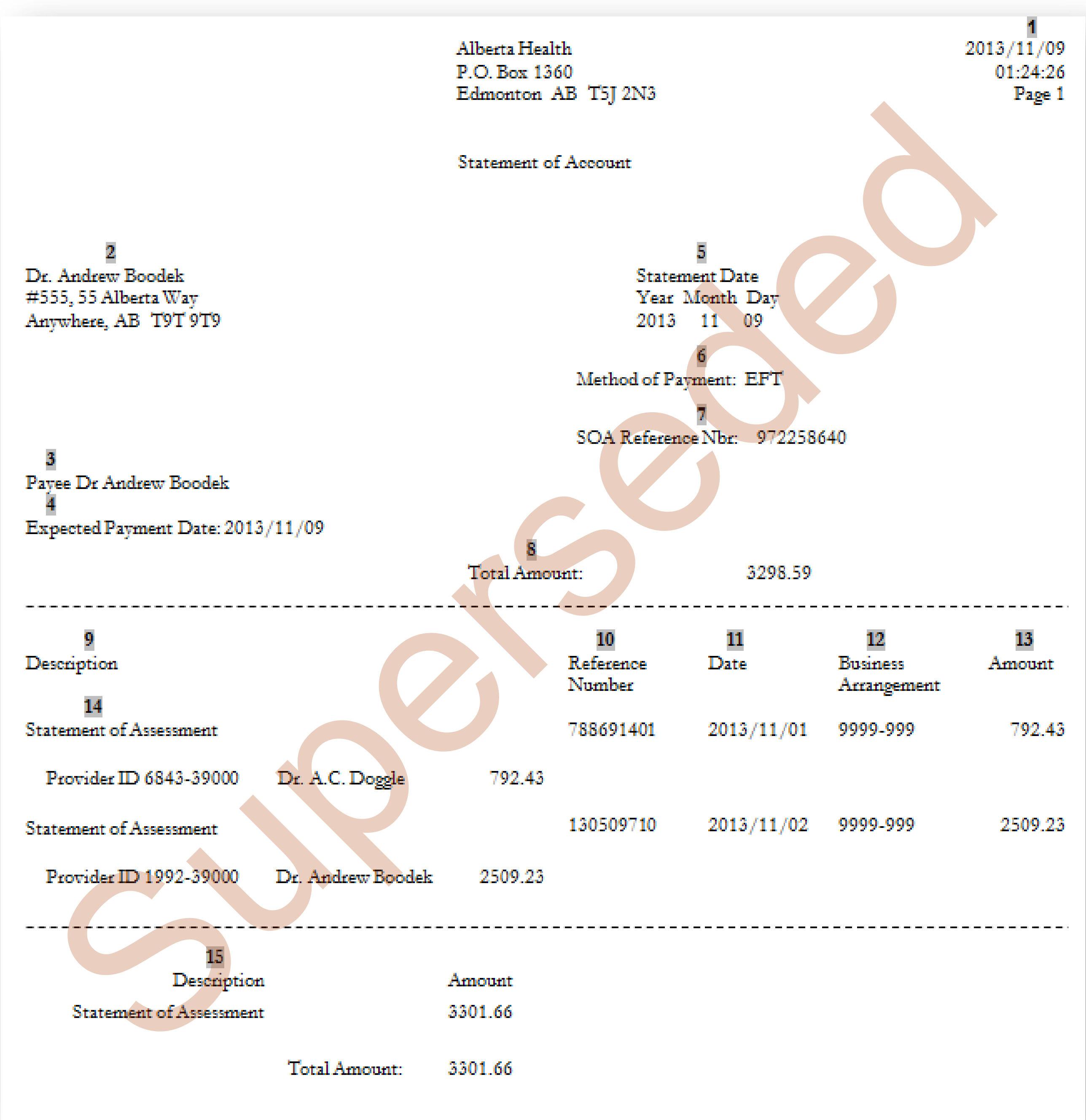
6.8 Statement of Account - Sample



1
Alberta Health
P.O. Box 1360
Edmonton AB T5J 2N3

2013/11/09
01:24:26
Page 1

Statement of Account

2
Dr. Andrew Boodek
#555, 55 Alberta Way
Anywhere, AB T9T 9T9

5
Statement Date
Year Month Day
2013 11 09

6
Method of Payment: EFT

7
SOA Reference Nbr: 972258640

3
Payee Dr Andrew Boodek

4
Expected Payment Date: 2013/11/09

8
Total Amount: 3298.59

9 Description			10 Reference Number	11 Date	12 Business Arrangement	13 Amount
14 Statement of Assessment			788691401	2013/11/01	9999-999	792.43
Provider ID 6843-39000	Dr. A.C. Doggle	792.43				
Statement of Assessment			130509710	2013/11/02	9999-999	2509.23
Provider ID 1992-39000	Dr. Andrew Boodek	2509.23				

15 Description	Amount
Statement of Assessment	3301.66
Total Amount:	3301.66

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6.9 Statement of Account – Field Descriptions

Please refer to section 6.8 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.

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6.10 Monitoring and Compliance

The AHCIP compensates providers in accordance with the Schedules 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 department 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 errors or issues in the claims that were paid 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:

- A review of the claims data for a specific period of time to determine any errors or issues;
- A review of samples of patients charts, or other provider office or facility records to verify the errors or issues;
- Communication via letters with the providers to inform about the claim errors or issues, request explanations or documentation (e.g. patient charts), and to provide a summary of the findings and the financial amount outstanding, if any.

This compliance review is an interactive process through which providers have the opportunity to provide documentation and comments. In addition, Alberta Health may visit a provider's office to better understand his or her practice and to view patient files. 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 costs claimed. This requires providers to understand and apply the claim schedule and to ensure that their billing staff understand the Alberta Health rules and submit claims appropriately.

Misunderstanding of individual items in the schedule or the relevant General Rules may lead to inappropriate claim submission. As detailed in Section 15(2) of the *Alberta Health Care Insurance Regulation*, providers must retain the original documentation relating to the goods or services provided 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 Care Protection Act*.

Questions regarding monitoring and compliance can be sent by e-mail to MIbranch@gov.ab.ca.

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7.0 Schedule of Benefits

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

The Schedules 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 health service codes and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.
Price List	Lists all health service codes 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.

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7.1 Procedure List

This component of the Schedule of Benefits lists all services. To help you understand how the Procedure List works, please refer to the sample page from the Schedule of Oral and Maxillofacial Surgery Benefits on the next page 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 description for the anatomical region; e.g., XV. Operations on the Musculoskeletal System.

2. This field is a heading used to identify body part and type of procedures.

3. The health service code for the service performed.

4. A description of the health service code.

5. BASE amount is the fee for the service, before application of any modifiers. This may be a dollar amount or the code BY ASSESS. (The fee payable for a BY ASSESS procedure depends on supporting information that must be submitted with the claim.)

6. 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 physician providing the related anaesthetic service.

7. The NOTE field contains special instructions for a health service code.

8. The letter V beside the base rate means the fee payable varies according to the practitioner's skill code, specific modifiers on the claim and other variables.

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7.2 Procedure List – Sample Page

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ALBERTA HEALTH CARE INSURANCE PLAN
Schedule of Dentistry Benefits
Part B - Procedure List

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As of 2011/10/01

1 XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

88 OPERATIONS ON FACIAL BONES AND JOINTS (cont'd)

2 88.1 Open reduction of facial fractures (cont'd)

88.16 Open reduction of orbital fracture (cont'd)

Code	Description	5 BASE	6 ANE
88.16D	Exploration of orbital blowout fracture and reconstruction with insertion of subperiosteal implant	509.12	171.63

88.19 Open reduction of other facial fractures

Code	Description	BASE	ANE
88.19DA	With mini-plate fixation of fractured frontal bone via coronal approach	1,285.31	961.11
	NOTE: 15.03A can be paid in addition		

88.2 Incision of facial bone without division

88.29 Other incision of facial bone without division

Code	Description	BASE	ANE
88.29C	Removal of foreign body from bone	531.98	326.09
88.29E	Subcondylar closed osteotomy	1,744.97	1,132.73
88.29F	Subcondylar open osteotomy	1,744.97	600.69
88.29H	Anterior segmental osteotomy of the mandible	1,744.97	600.69
88.29M	Anterior segmental osteotomy of the maxilla	1,744.97	590.54
88.29T	Oblique osteotomy of ramus	1,971.70	600.69
	That including bone graft		
3 88.29U	Osteotomy of condylar neck 4	1,744.97	1,181.08
88.29V	Sagittal split osteotomy	1,744.97	626.33
88.29X	Inverted L osteotomy	1,744.97	1,046.92
88.29Y	C osteotomy	1,744.97	1,064.08
88.29DB	Inverted L osteotomy including bone graft	2,128.49	789.48
88.29DC	Osseodistraction and Bone Lengthening, including management of advancement	2,301.05	858.13
88.29DD	Le Fort I	1,744.97	680.02
88.29DE	Le Fort I with bone graft	2,128.49	789.48
88.29DF	Le Fort I, segmental without bone graft	1,971.70	652.18
88.29DG	Le Fort I, segmental with bone graft	2,326.96	751.60
	NOTE: 88.29DJ, 88.29DK may be claimed in addition for harvesting. 7		
88.29CA	Le Fort I in cleft palate	1,744.97	652.18
88.29DA	Le Fort I in cleft palate	2,128.49	652.18
88.29N	Le Fort II osteotomy	2,326.64	1,390.17
88.29FA	Le Fort III osteotomy	2,520.54	1,544.63
88.29GA	Posterior segmental osteotomy of the mandible	1,744.97	557.78
88.29HA	Total dent-alveolar osteotomy of the mandible	1,744.97	1,064.08
88.29TA	Posterior segmental osteotomy of the maxilla	1,744.97	617.85
88.29MA	Lower Border ostectomy	1,744.97	600.69
88.29NA	Removal of loose bodies	117.32 V	154.46
88.29PA	Surgical lavage	281.57	143.16
	NOTE: May not be claimed with diagnostic TMJ arthroscopy.		
88.29QA	Surgical lysis of adhesions	117.32 V	8 137.30
88.29RA	Mechanical debridement	117.32 V	137.30
88.29SA	Laser debridement	117.32 V	145.88

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7.3 Price List

This component of the Schedule of Benefits displays the base fee for the different health service codes, as well as modifier definitions arranged by type, code and description.

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

1. 88.29X is the health service code. See the Procedure List for a description of this code.

2. $1744.97 is the base fee for this procedure.

3. This field lists all modifier types applicable to this health service code.

4. A listing of all modifier codes that affect payment, applicable to this health service code. For example:
   - A ROLE modifier code entered on a claim indicates the function performed by the practitioner in providing the service (e.g., surgical assist).
   - SAU modifier code indicates the number of surgical assist time unit services that may be claimed. (Supporting text is required if this maximum is exceeded.)

5. The Y in this field identifies each explicit modifier. When applicable, these modifier codes must be manually 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 SA is used and more than one call is entered on the claim, the implicit modifier SAU is assigned by the claims processing system. The base fee is then replaced by $90.24 for the first hour of surgical assist time, plus $22.40 is added for each additional call entered on the claim.

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

8. The category code for each health service code. The number 14 here indicates a major procedure.

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7.4 Price List – Sample Page

ALBERTA HEALTH CARE INSURANCE PLAN
Schedule of Dentistry Benefits
Part C - Price List

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As of 2011/10/01

HSC	BASE RATE	TYPE	CODE	EXPLCT	ACTION	AMOUNT	CAT
1	2	3	4	5	6	7	8
88.29X	1744.97	BMI	BMIANE	Y	Increase By	25%	14
		BMI	BMIANT	Y	Increase By	25%	
		BMI	BMISRG	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	1046.92	
		ROLE	ANEST	Y	Replace Base	17.90	
		ROLE	SA	Y	Replace Base	90.24	
		ROLE	SOSS	Y	Replace Base	279.39	
		ANU	ANU				
			1		For Each Call Pay Base At	100%	
			2-105		For Each Call Increase By	17.90	
		SAU	SAU				
			1		For Each Call Pay Base At	100%	
			2-21		For Each Call Increase By	22.40	
		SOSU	SOSU				
			1		For Each Call Pay Base At	100%	
			2-33		For Each Call Increase By	93.12	
		SURC	DEV	Y	Increase By	87.18	
		SURC	DNTAM	Y	Increase By	209.24	
		SURC	DNTPM	Y	Increase By	209.24	
		SURC	DWK	Y	Increase By	87.18	
		SURC	EV	Y	Increase By	46.70	
		SURC	NTAM	Y	Increase By	112.04	
		SURC	NTPM	Y	Increase By	112.04	
		SURC	WK	Y	Increase By	46.70	
		LVP	LVP75	Y	Reduce Base To	75%	

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APPENDICES

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Appendix A – Contact Information and Resources

A.1 Alberta Health Contact Information

Mailing address
Correspondence can be mailed to:

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

Telephone

Information	Contact
Information about: • Claim assessment or reassessments • General billing inquiries • Maximum of three issues per call	**780-422-1600** (8:15 a.m. – 4:30 p.m.) **Do not give out this number** to the general public
Information about: • Practitioner or facility registration • Changes to address, skill, business arrangement • Direct deposit, banking information	**780-422-1522** (8:15 a.m. – 4:30 p.m.) **Do not give out this number** to the general public
Obtain PHNs for patients who do not have their Alberta personal health card or number with them at the time of service • Maximum of three PHNs per call	**780-415-2288** (8:15 a.m. – 4:30 p.m.) **Do not give out this number** to the general public

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Check an Alberta patient's PHN and/or its status for a specific date	**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	**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	**780-415-8731** (24 hour access) The public also uses this number to request other information.
General inquiries about AHCIP coverage and benefits	**780-427-1432** (8:15 a.m. – 4:30 p.m.) The public also uses this number to request information.

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A.2 Alberta Health Resources

To facilitate the submission of claims to the AHCIP, Alberta Health provides practitioners with a variety of resources, including:

- Schedule of Benefits as applicable to the practitioner's discipline
- Allied Health Practitioner's Resource Guide
- Bulletins
- Interactive voice response (IVR) system

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- Diagnostic Code Supplement (ICD9)
- Facility Listing
- Statement of Assessment and Statement of Account

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.

A.3 Obtaining Alberta Health Resource Material

Virtually all resource material required by practitioners for billing purposes is available for printing/downloading on the Alberta Health website. Because new documents are posted and existing documents updated as needed, we recommend you check online regularly to ensure you are referencing the most current documents and information.

- Claim Forms are located at www.health.alberta.ca/AHCIP/forms-claims.html.
- Health business user forms are located at www.health.alberta.ca/professionals/resources.html.

Note: The Request for Personal Health Numbers form – AHC0406 is **not** available online. To request a supply of this form, call 780-415-2288 (Toll-Free 310-0000 and then enter 780-415-2288 when prompted. (See Section 2.8 - Patient PHN Problems.)

- Schedules of Benefits for allied health services are located at http://www.health.alberta.ca/professionals/allied-services-schedule.html.
- Diagnostic Code Supplement (ICD9), Explanatory Code List, Facility Listing and Allied Health Practitioner's Resource Guide are located at www.health.alberta.ca/professionals/fees.html.
- Bulletins, which contain information about Schedule of Benefits amendments and advice regarding claim submissions, clarification of assessment, etc., are produced as necessary and posted at www.health.alberta.ca/professionals/bulletins.html.

Note: 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.

Requests for clarification of general rules and billing policies must be submitted to Alberta Health in writing or faxed to 780-422-3552.

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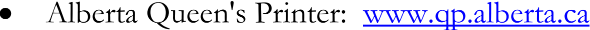
A.4 Obtaining Alberta Health Legislation and Regulations

Copies of the Alberta Health legislation and regulations can be downloaded from the following websites:

- Alberta Health: www.health.alberta.ca/about/health-legislation.html

- Alberta Queen's Printer: www.qp.alberta.ca

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Appendix B – Valid Provincial/Territorial Health Cards

Note: 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 www.health.alberta.ca/professionals/resources.html

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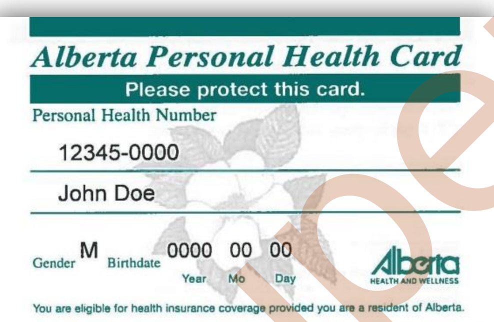
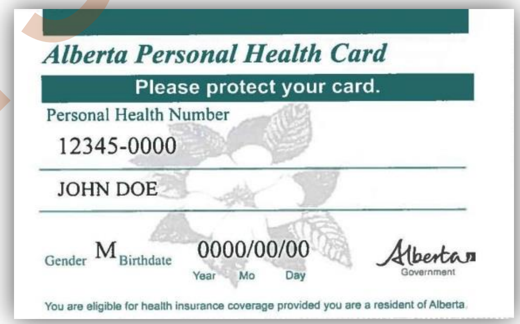
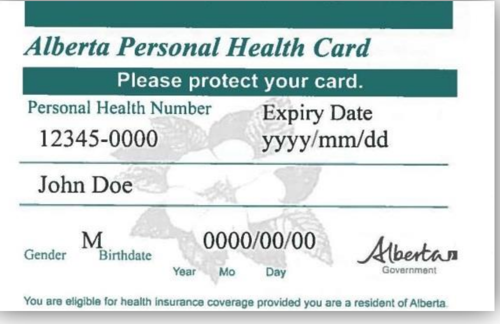
ALBERTA

- 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 temporary residents such as foreign workers, students and their dependents' have an expiry date.







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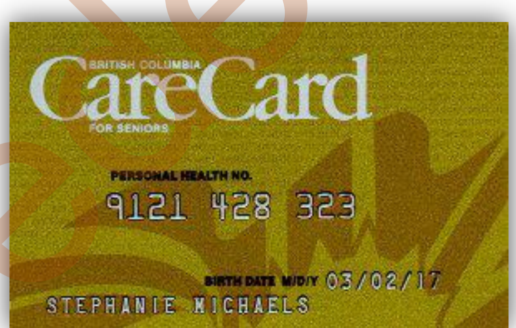
BRITISH COLUMBIA

- 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.



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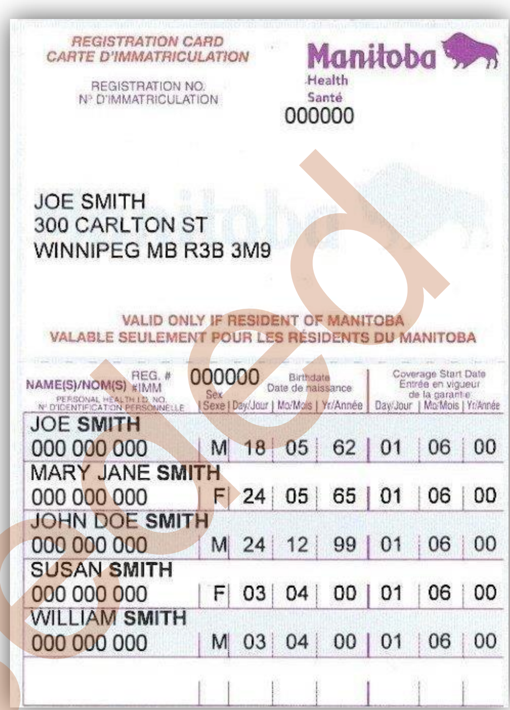
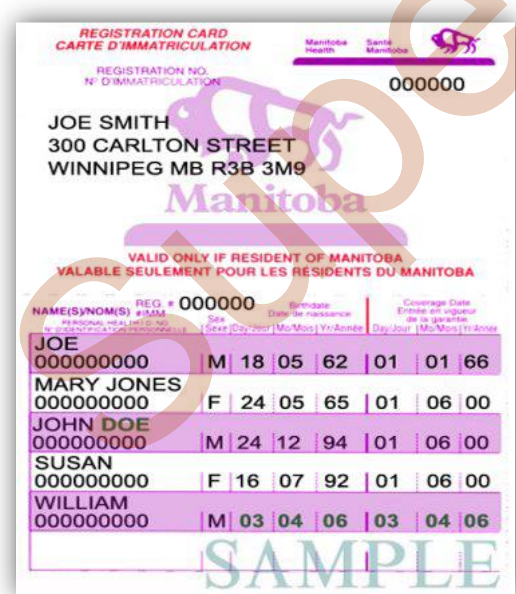
MANITOBA

- 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.)





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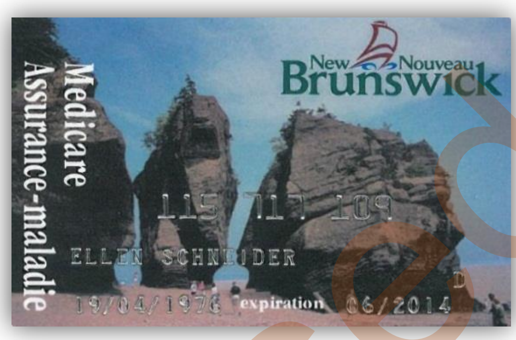
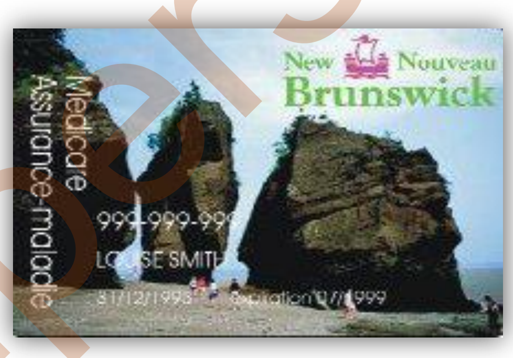
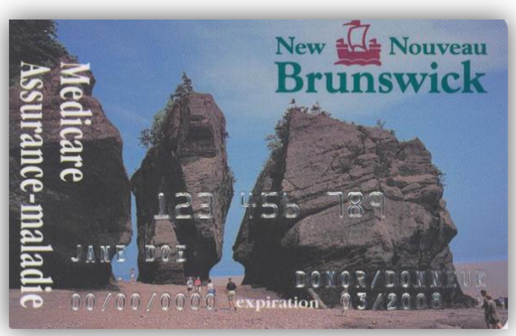
NEW BRUNSWICK

- 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.







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NEW FOUNDLAND AND LABRADOR

- The 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. New cards issued this year include a bar code.

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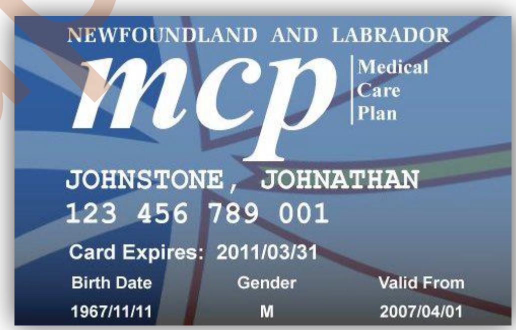
Note: The Newfoundland and Labrador health card shown below has expired and is no longer valid.



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NORTHWEST TERRITORIES

- A new health care card for NWT came into effect in February 2016 showing the new visual elements of the Government of the NWT.
- The new health care card does not affect the NWT residents' health care coverage.
- The old NWT health card, which features a northern landscape as a faint background screen, is valid until 2019.

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NOVA SCOTIA

- 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.

.

Note: 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

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NUNAVUT

- 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.

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ONTARIO

- 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.
- 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.

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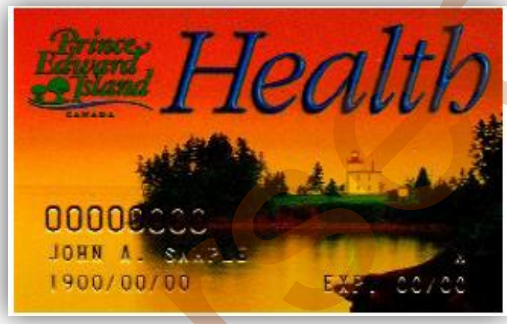
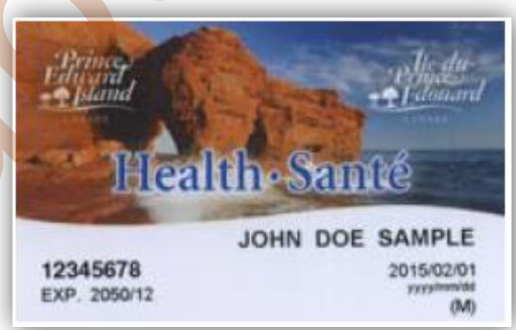
PRINCE EDWARD ISLAND

- A new bilingual health care card for 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





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QUEBEC

- The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan.
- 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.)

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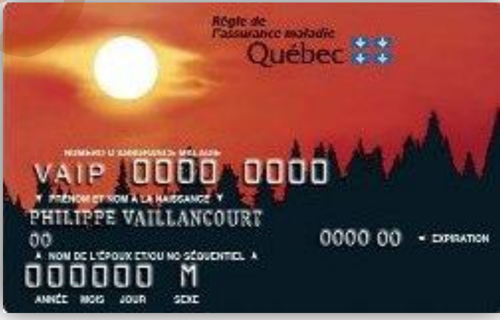

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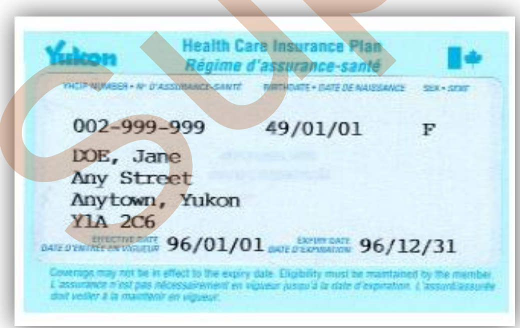
SASKATCHEWAN

- 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

- The plastic cards are light blue in color with dark blue print.
- 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 physician 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.



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Appendix C – 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 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.

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 to a patient above the current rate listed in the applicable Schedule of Benefits. Balance billing is not allowed for services listed in the Schedule of Optometric Benefits, Schedule of Oral and Maxillofacial Surgery Benefits or Schedule of Podiatric Surgery Benefits.

Basic health benefits
Services deemed medically required according to the *Canada Health Act* and provided by physicians, 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.

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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.

By assessment
A specific procedure with a health service code 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.

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 and Wellness 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.

Default skill
The primary skill used by a practitioner to perform all or most services. Practitioners 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.

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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., 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.

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 practitioners 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 health service code 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.

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General hospital
Facility designed for provision of diagnostic services, medical or surgical treatment in the acute phase for adults and children and obstetrical care.

Good faith policy
A policy that allows Alberta practitioners to claim a one-time payment for basic health care services provided to eligible Alberta residents unable to produce a current Alberta Personal Health Card or personal health number at the time of service. This policy only applies when practitioners believe the patient to be an Alberta resident eligible for coverage.

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

Health service code
A code that identifies services and procedures listed in the Schedules 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 practitioner 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.

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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 Alberta Health 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 or the RCMP, 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.

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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, that 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.

Submitter
(See Accredited submitter.)

ULI
Unique Lifetime Identifier. (See PHN.)

Unlisted procedure
A procedure that does not have a health service code listed in the Schedule of Benefits. If applicable, 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 health service code changes. Example: A dentist's consultation fee varies (is paid at a different rate) as compared with that of an oral surgeon.

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