Physician's Resource Guide

Alberta

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

Ministry: Alberta Health

Date of publication: March 14, 2024

Title of publication: Alberta Health Physician's Resource Guide

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

Contents

Introduction

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

The information in this guide will help you:

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

This guide is designed for use in conjunction with the Schedule of Medical Benefits (SOMB). A current copy of the SOMB is available online at https://www.alberta.ca/fees-health-professionals.aspx.

Whenever the Schedule is updated, the new version is posted on our website for your use.

1.0 AHCIP Basics for the Physician

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

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

1.1 Claiming Services from the AHCIP

Physicians may submit claims to the AHCIP for medically required insured services provided to:

- eligible Alberta residents (Section 2.1 – Alberta Residents), and
- residents of other Canadian provinces/territories (except Quebec residents) under the medical reciprocal program. (Section 5.2 - Claims for Services Provided to Out-of-Province Patients.)
- Claims are submitted using the electronic H-Link method, either by an existing accredited submitter or the physician can apply to become their own submitter. (Section 1.6.4 - The Business Arrangement and the Submitter.)

1.2 Services Not Claimable from the AHCIP

- Services that are not insured may not be claimed from the AHCIP.
- Physicians 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 physician for support.
- When one physician sends a member of his/her family to another physician, the second physician may not claim for a consultation. A referral from a patient's family member is not considered a formal referral for the purposes of billing a consultation service.
- Claims that are the responsibility of the Workers' Compensation Board (WCB) must not be submitted to the AHCIP. They must be submitted directly to the WCB. (Section 5.8 – Workers' Compensation Board (WCB) claims.)

1.3 Registering as a New Physician

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

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

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

> Alberta Health does **not** register **out-of-province** physicians and service providers for the purposes of receiving practitioner IDs to provide virtual health care services to Albertans. Practitioner ID numbers are only granted to physicians and providers that are physically working in the province of Alberta (See 5.4 Virtual Health Claims)

1.4 Other Forms a Physician May Need to Complete

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

Facility Registration AHC0910A	To set up a new facility, end a facility, or change information on an existing facility. The CPSA Clinic registration letter must accompany this form.
Business Arrangement and Relationships Application AHC11236	To set up a new business arrangement, change or end information on an existing business arrangement, or to change information about your relationship with an existing business arrangement. In addition, this form is used to authorize an accredited submitter to submit claims on your behalf, or to change from one submitter to another.
Notification of Business Address Change AHC11459	To update your current business address to a new business address.
Direct Deposit Request AHC1143	To change the direct deposit banking information for your claim payments.
Physician Skill Validation AHC13188	Physicians who are providing services under the AHCIP need to complete this form and have it signed by the facility medical director to update all skills.
Out of Province Physician Registration Attestation AHC13398	Physicians and/or Allied providers out of province who wish to provide healthcare services to Albertans according to the AHCIP and require a practitioner ID to be registered in Alberta.

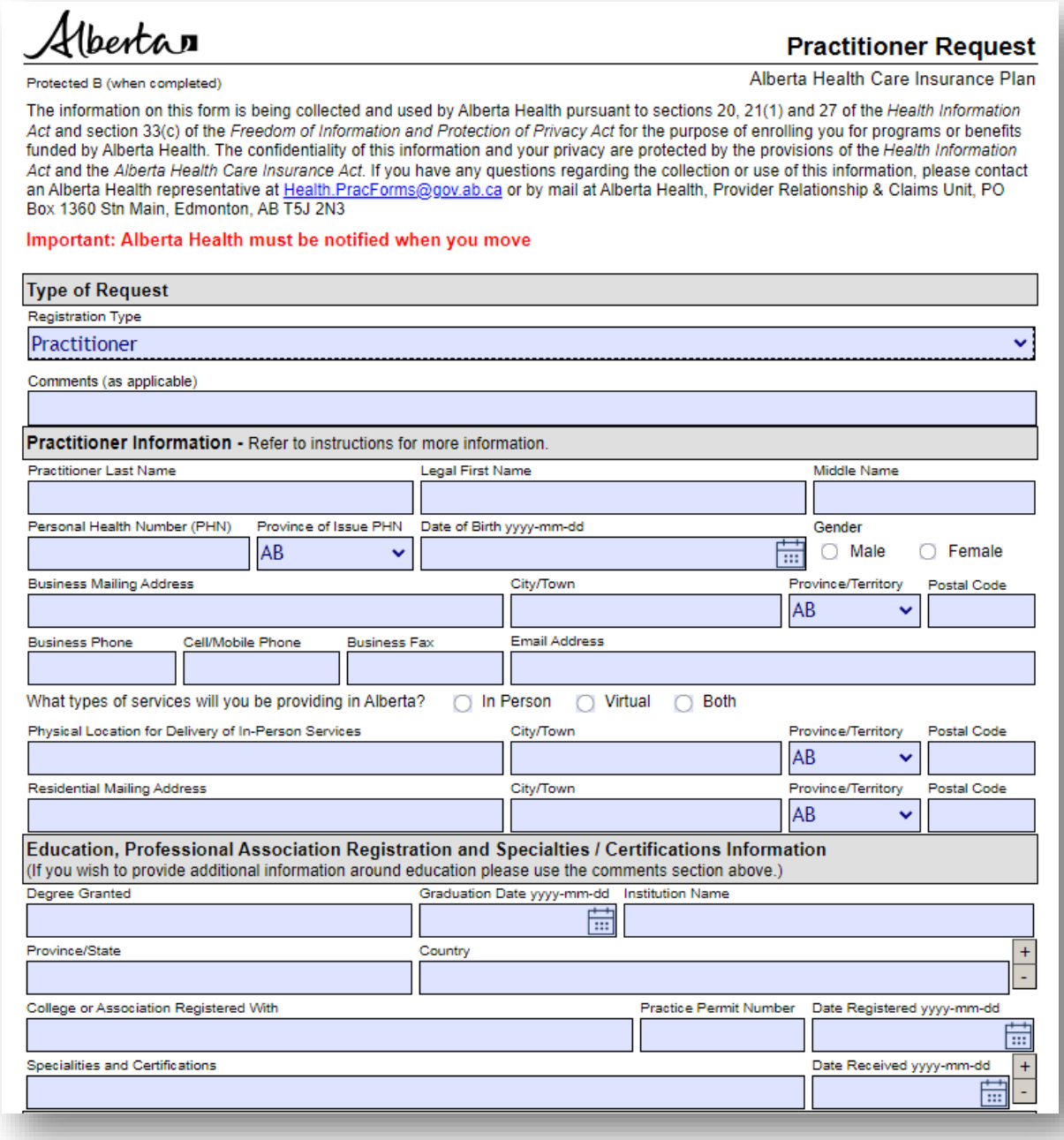
To avoid delays in the processing and payment of claims, please advise Alberta Health of all changes to practitioner information in advance of the date the changes are effective.

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

1.5 Sample Forms

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

1.5.1 Practitioner Request Form (AHC11234) – Sample



Alberta

Practitioner Request

Protected B (when completed)

Alberta Health Care Insurance Plan

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

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Practitioner

Comments (as applicable)

Practitioner Information - Refer to instructions for more information.

Practitioner Last Name | Legal First Name | Middle Name

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

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

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

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

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

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

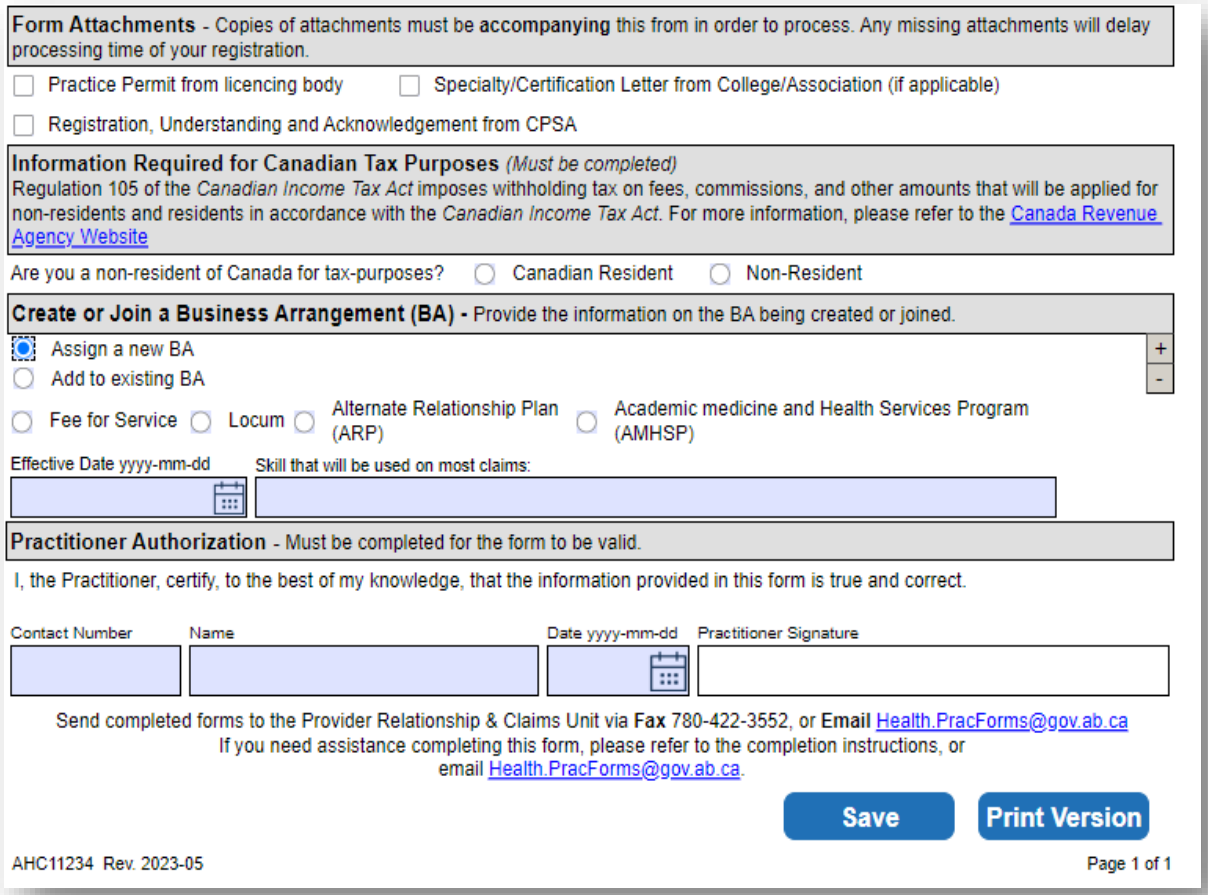
Education, Professional Association Registration and Specialties / Certifications Information
(If you wish to provide additional information around education please use the comments section above.)

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

Province/State | Country

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

Specialities and Certifications | Date Received yyyy-mm-dd



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

- ☐ Practice Permit from licencing body
- ☐ Specialty/Certification Letter from College/Association (if applicable)
- ☐ Registration, Understanding and Acknowledgement from CPSA

Information Required for Canadian Tax Purposes *(Must be completed)*

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

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

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

- ◉ Assign a new BA
- ○ Add to existing BA

+ -

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

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

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

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

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

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

Save | Print Version

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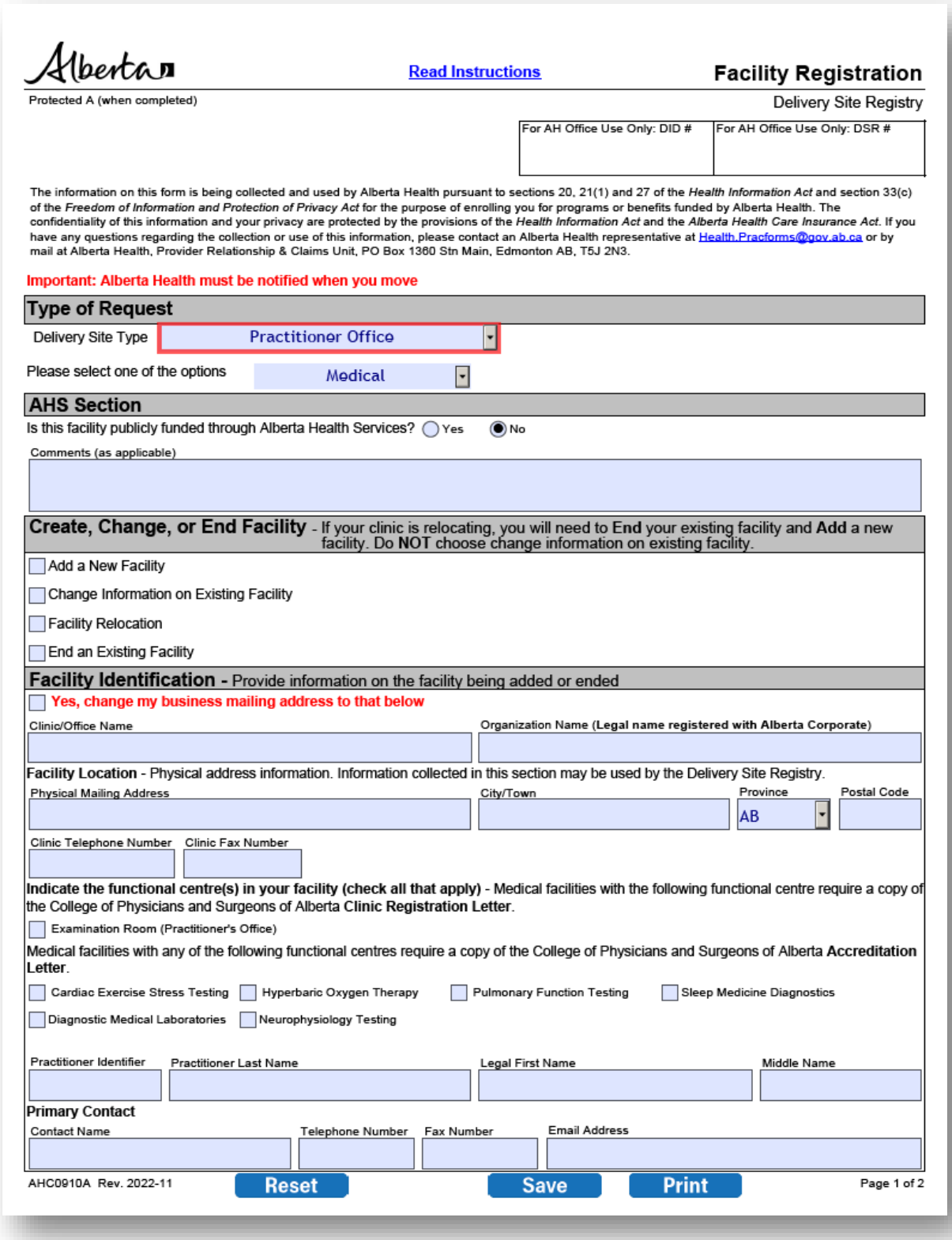
1.5.2 Facility Registration Form (AHC0910A) – Sample



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Read Instructions

Facility Registration

Protected A (when completed)

Delivery Site Registry

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

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

Important: Alberta Health must be notified when you move

Type of Request

Delivery Site Type: Practitioner Office

Please select one of the options: Medical

AHS Section

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

Comments (as applicable)

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

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

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

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

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

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

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

Clinic Telephone Number | Clinic Fax Number

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

☐ Examination Room (Practitioner's Office)

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

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

☐ Diagnostic Medical Laboratories ☐ Neurophysiology Testing

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

Primary Contact

Contact Name | Telephone Number | Fax Number | Email Address

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

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

Practitioner Name	Date yyyy-mm-dd	Signature

Clinic or Practice Owner Authorization

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

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

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

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

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

email Health.PracForms@gov.ab.ca

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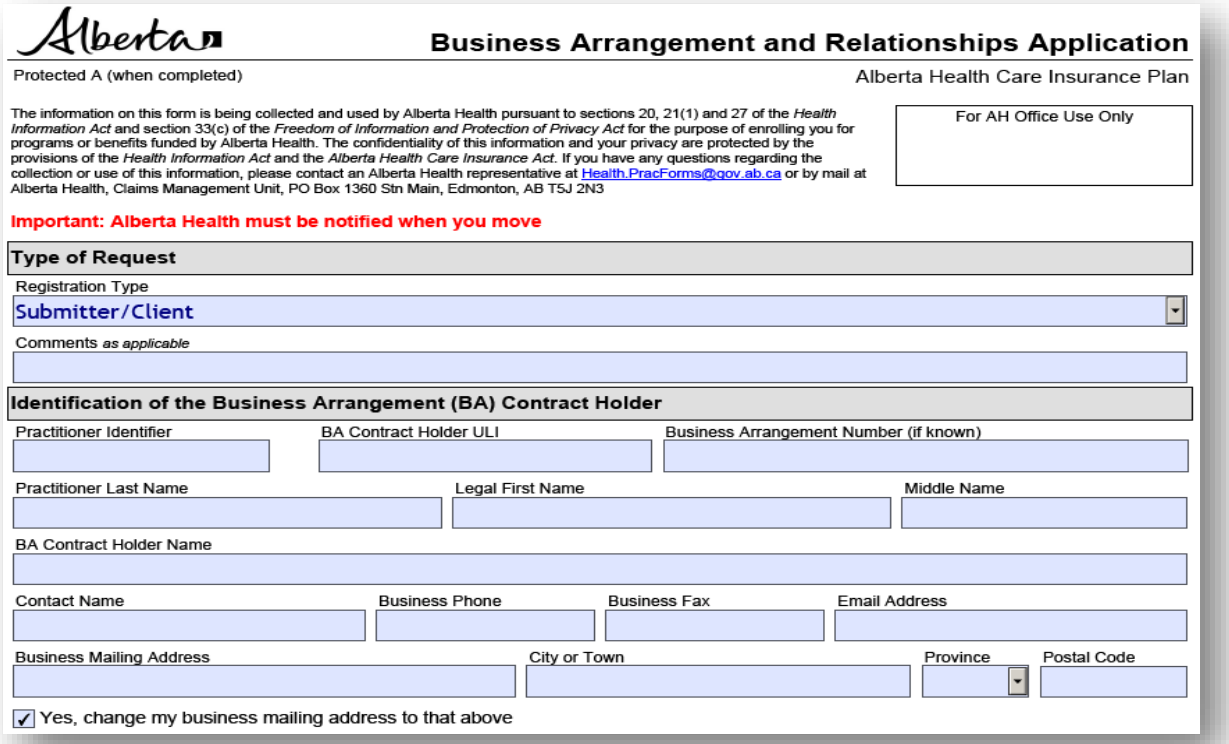
1.5.3 Business Arrangement and Relationships Form (AHC11236) – Sample



Alberta

Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Submitter/Client

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

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

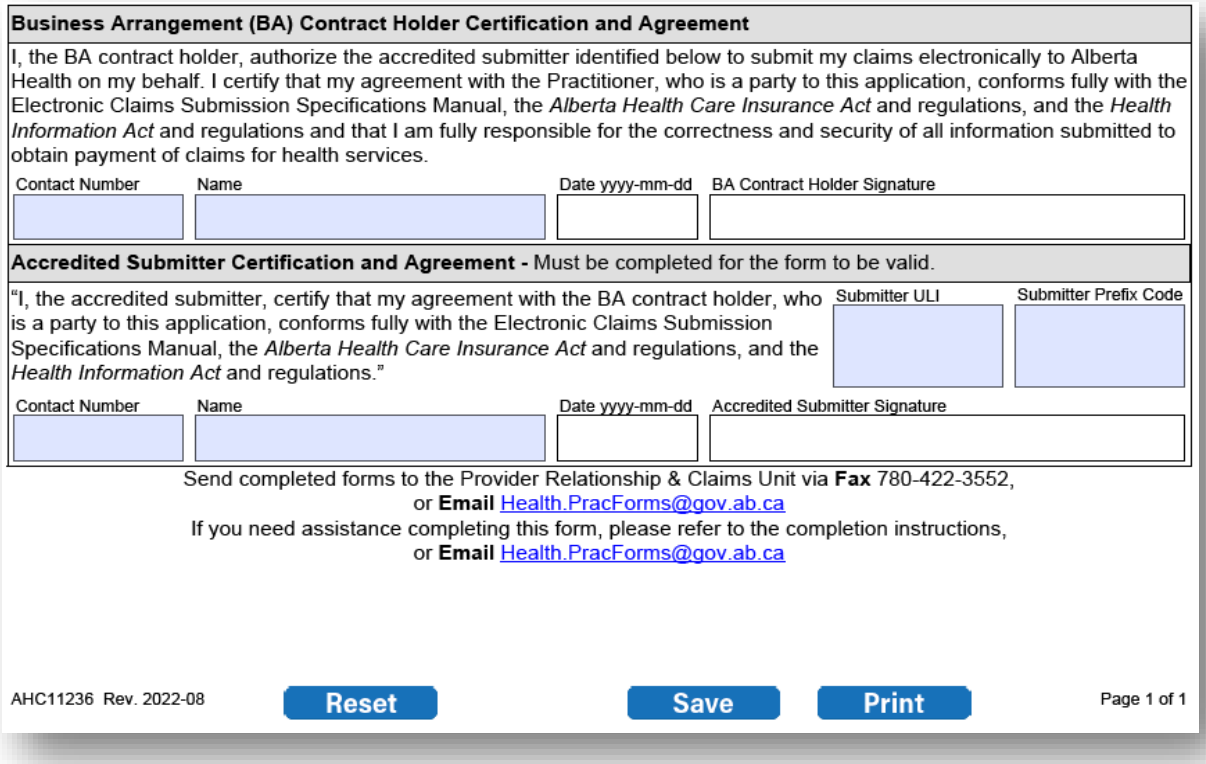
Practitioner Last Name | Legal First Name | Middle Name

BA Contract Holder Name

Contact Name | Business Phone | Business Fax | Email Address

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

☑ Yes, change my business mailing address to that above



Business Arrangement (BA) Contract Holder Certification and Agreement

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

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

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

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

Submitter ULI | Submitter Prefix Code

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

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

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

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Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type: Business Arrangement Request

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

○ Practitioner ◉ Professional Corporation (PC) ○ Clinic

Practitioner Identifier | PC/Clinic Name

Practitioner Last Name | Legal First Name | Middle Name

Contact Name | Business Phone | Business Fax | Email Address

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

☐ Yes, change my business mailing address to that above

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

☑ Assign a new BA

☐ Change BA effective date

☐ Change my BA default skill code

☐ End my relationship with the BA

☑ Change where my statements are sent

BA Number

Send Statement of Account to: Me

Send Statement of Assessment to: Me

Business Arrangement (BA) Contract Holder Certification and Agreement

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

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

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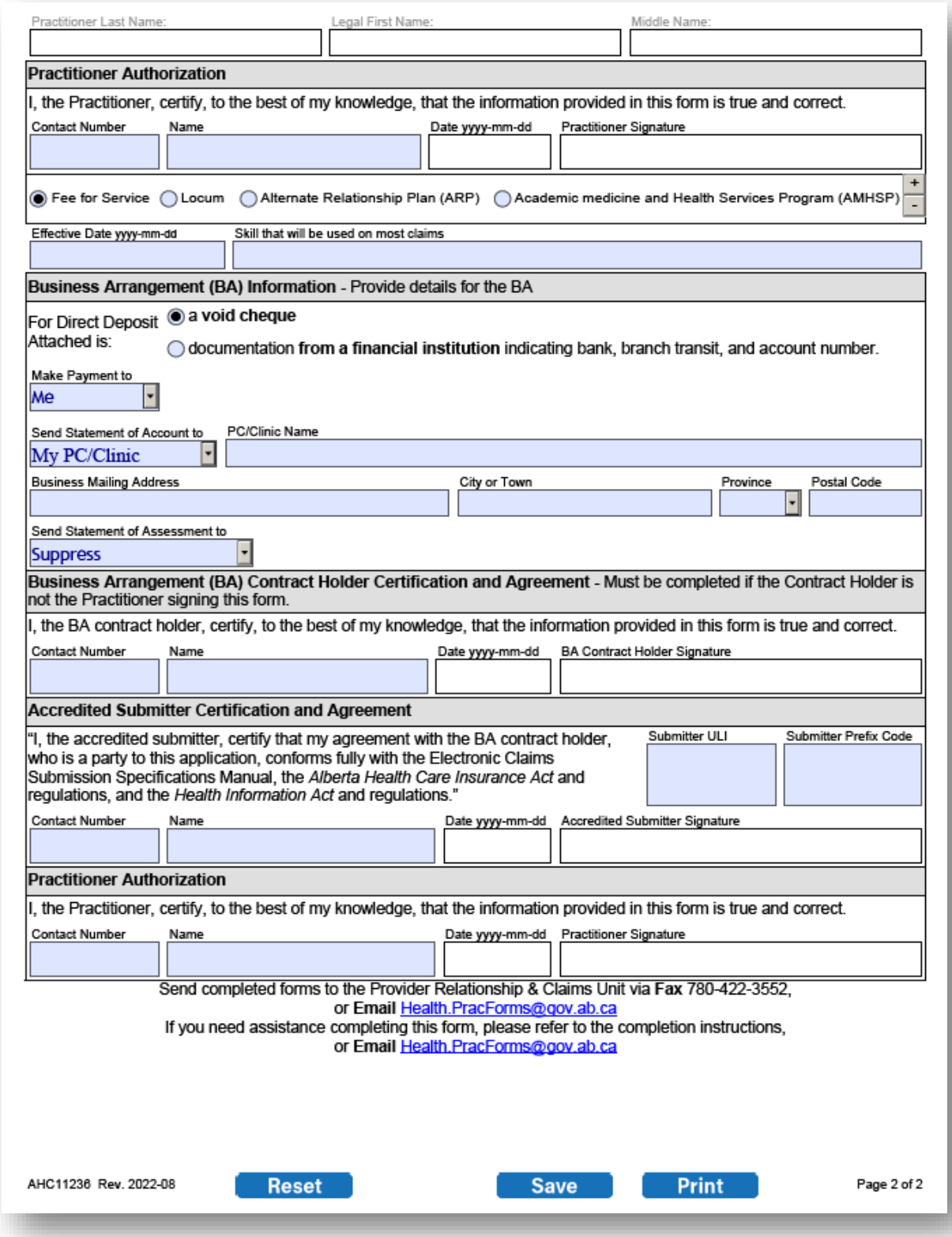

Practitioner Last Name: | Legal First Name: | Middle Name:

Practitioner Authorization

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

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

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

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

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

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

Make Payment to: Me

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

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

Send Statement of Assessment to: Suppress

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

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

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

Accredited Submitter Certification and Agreement

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

Submitter ULI | Submitter Prefix Code

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

Practitioner Authorization

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

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

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

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

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Business Arrangement and Relationships Application

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type

Business Arrangement/Service Provider

Comments as applicable

Identification of the Business Arrangement (BA) Contract Holder

BA Contract Holder Name

Contact Name | Business Phone | Business Fax | Email Address

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

☐ Yes, change my business mailing address to that above

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

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

☐ Add to existing BA

☐ Change my start date with BA

☐ Change the effective date of my BA Number

☐ Change my BA default skill code

☐ End my relationship with the BA

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

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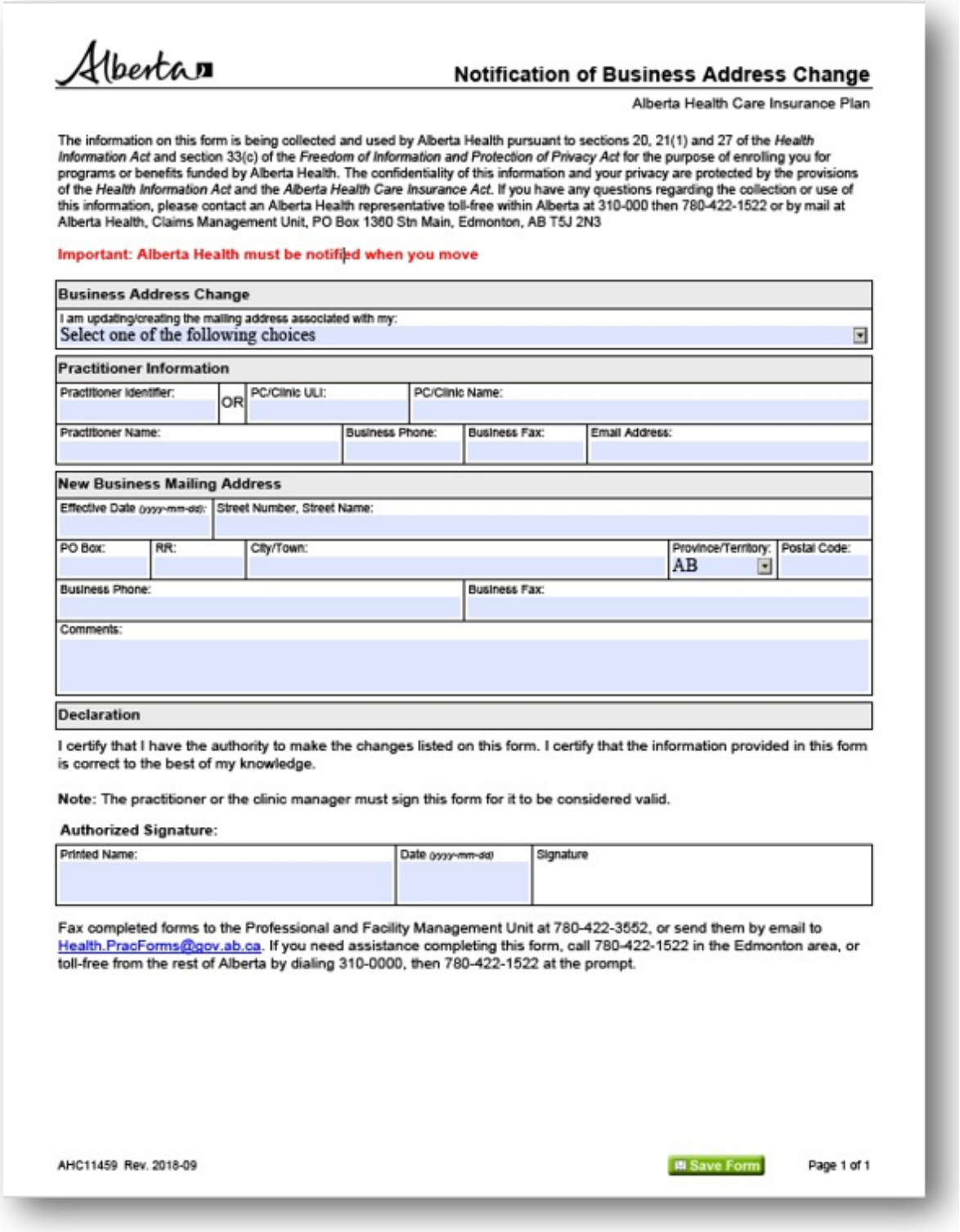
1.5.4 Notification of Business Address Change Form (AHC11459) – Sample



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Notification of Business Address Change

Alberta Health Care Insurance Plan

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Important: Alberta Health must be notified when you move

Business Address Change

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

Practitioner Information

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

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

New Business Mailing Address

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

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

Business Phone:	Business Fax:

Comments:

Declaration

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

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

Authorized Signature:

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

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

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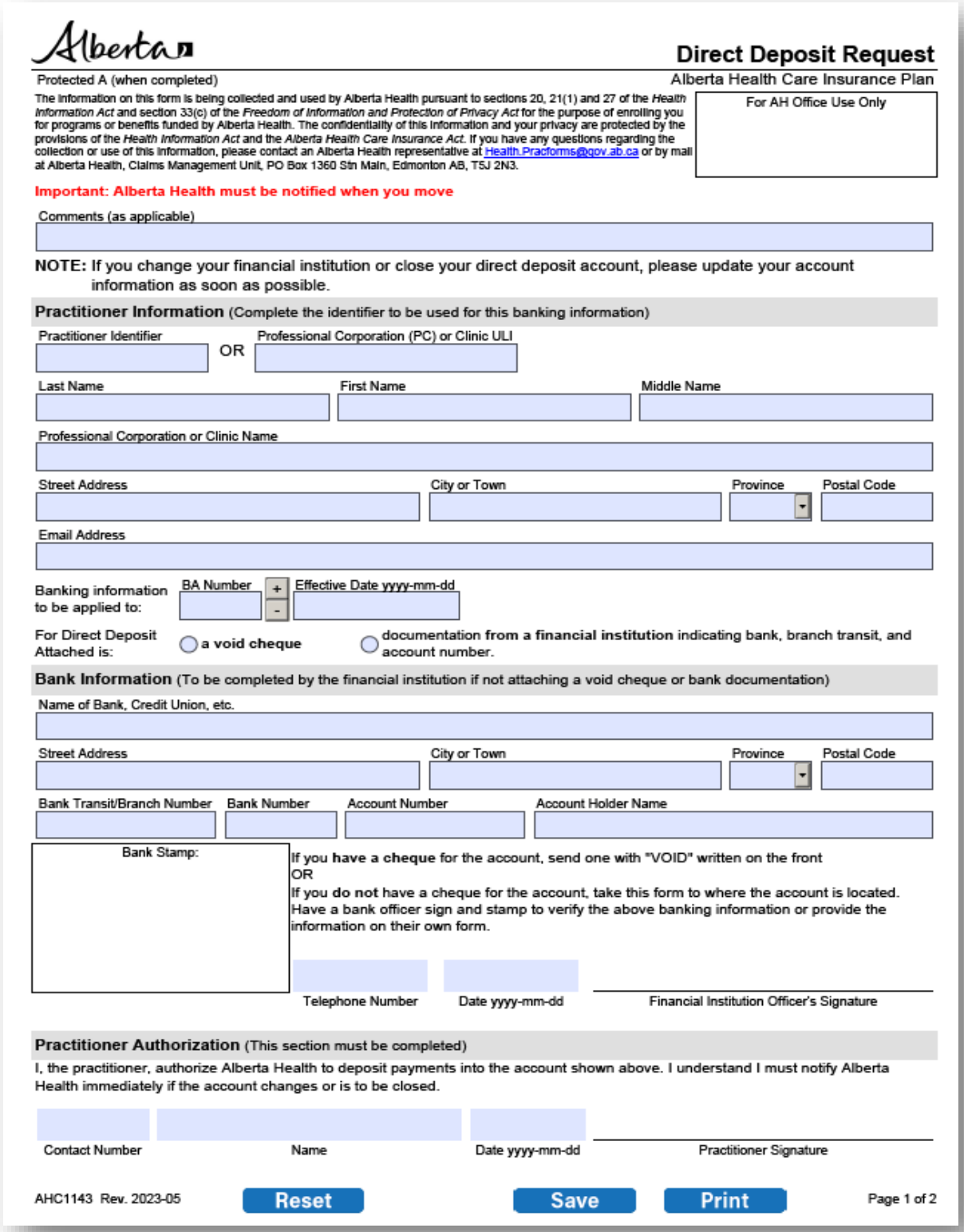
1.5.5 Direct Deposit Request (AHC1143) – Sample



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Direct Deposit Request

Protected A (when completed)

Alberta Health Care Insurance Plan

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For AH Office Use Only

Important: Alberta Health must be notified when you move

Comments (as applicable)

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

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

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

Last Name | First Name | Middle Name

Professional Corporation or Clinic Name

Street Address | City or Town | Province | Postal Code

Email Address

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

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

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

Name of Bank, Credit Union, etc.

Street Address | City or Town | Province | Postal Code

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

Bank Stamp:

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

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

Practitioner Authorization (This section must be completed)

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

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

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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 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, email Health.PracForms@gov.ab.ca.

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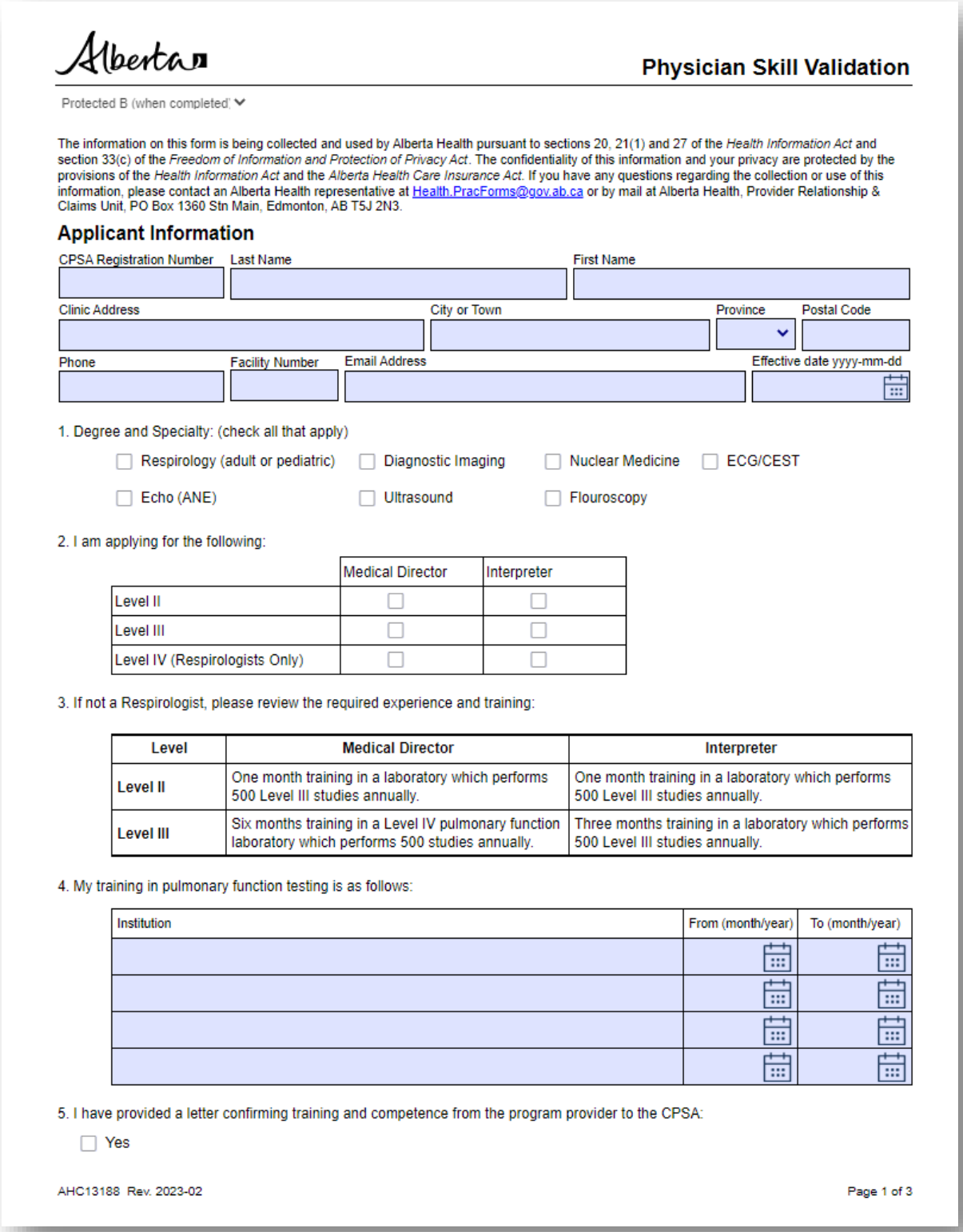
1.5.6 Physician Skill Validation (AHC13188) – Sample



Alberta

Physician Skill Validation

Protected B (when completed)

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*. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative at Health.PracForms@gov.ab.ca or by mail at Alberta Health, Provider Relationship & Claims Unit, PO Box 1360 Stn Main, Edmonton, AB T5J 2N3.

Applicant Information

CPSA Registration Number | Last Name | First Name

Clinic Address | City or Town | Province | Postal Code

Phone | Facility Number | Email Address | Effective date yyyy-mm-dd

1. Degree and Specialty: (check all that apply)

☐ Respirology (adult or pediatric) ☐ Diagnostic Imaging ☐ Nuclear Medicine ☐ ECG/CEST

☐ Echo (ANE) ☐ Ultrasound ☐ Flouroscopy

2. I am applying for the following:

	Medical Director	Interpreter
Level II	☐	☐
Level III	☐	☐
Level IV (Respirologists Only)	☐	☐

3. If not a Respirologist, please review the required experience and training:

Level	Medical Director	Interpreter
Level II	One month training in a laboratory which performs 500 Level III studies annually.	One month training in a laboratory which performs 500 Level III studies annually.
Level III	Six months training in a Level IV pulmonary function laboratory which performs 500 studies annually.	Three months training in a laboratory which performs 500 Level III studies annually.

4. My training in pulmonary function testing is as follows:

Institution	From (month/year)	To (month/year)

5. I have provided a letter confirming training and competence from the program provider to the CPSA:

☐ Yes

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6. My experience in pulmonary function testing includes:

Institution	From (month/year)	To (month/year)

7. I am applying for the following:

	Medical Director	Interpreter
Diagnostic Imaging (Full)	☐	☐
Ultrasound	☐	☐
ULTG - Obstetrics / Genecology	☐	☐
ULTO - Opthamology	☐	☐
ULTR - Full	☐	☐
ULTU - Urology	☐	☐
ULTV - Vascular	☐	☐
UROL - Urology	☐	☐
VISU - Visual Fields	☐	☐
VSSG - Vascular Surgery	☐	☐

8. I am applying for the following:

	Medical Director	Interpreter
ECG / CEST	☐	☐

9. I am applying for the following:

	Medical Director	Interpreter
ECHO (ANE)	☐	☐

10. I am applying for the following:

	Medical Director	Interpreter
Nuclear Medicine	☐	☐
NCMD (Specialist)	☐	☐
NUCM (Certification)	☐	☐

11. I am applying for the following:

	Medical Director	Interpreter
Flouroscopy	☐	☐
Radiologist	☐	☐
Non-Radiologist	☐	☐

Acknowledgment and Consent

I understand and agree that I have the burden of providing adequate, current and correct information for the proper evaluation of my professional competence, qualifications, licensure, and other qualifications. I understand and agree to respond to any inquiries about such information to the satisfaction of Alberta Health.

Applicant Printed Name	Date yyyy-mm-dd	Applicant Signature

Medical Director Printed Name	Date yyyy-mm-dd	Medical Director Signature

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

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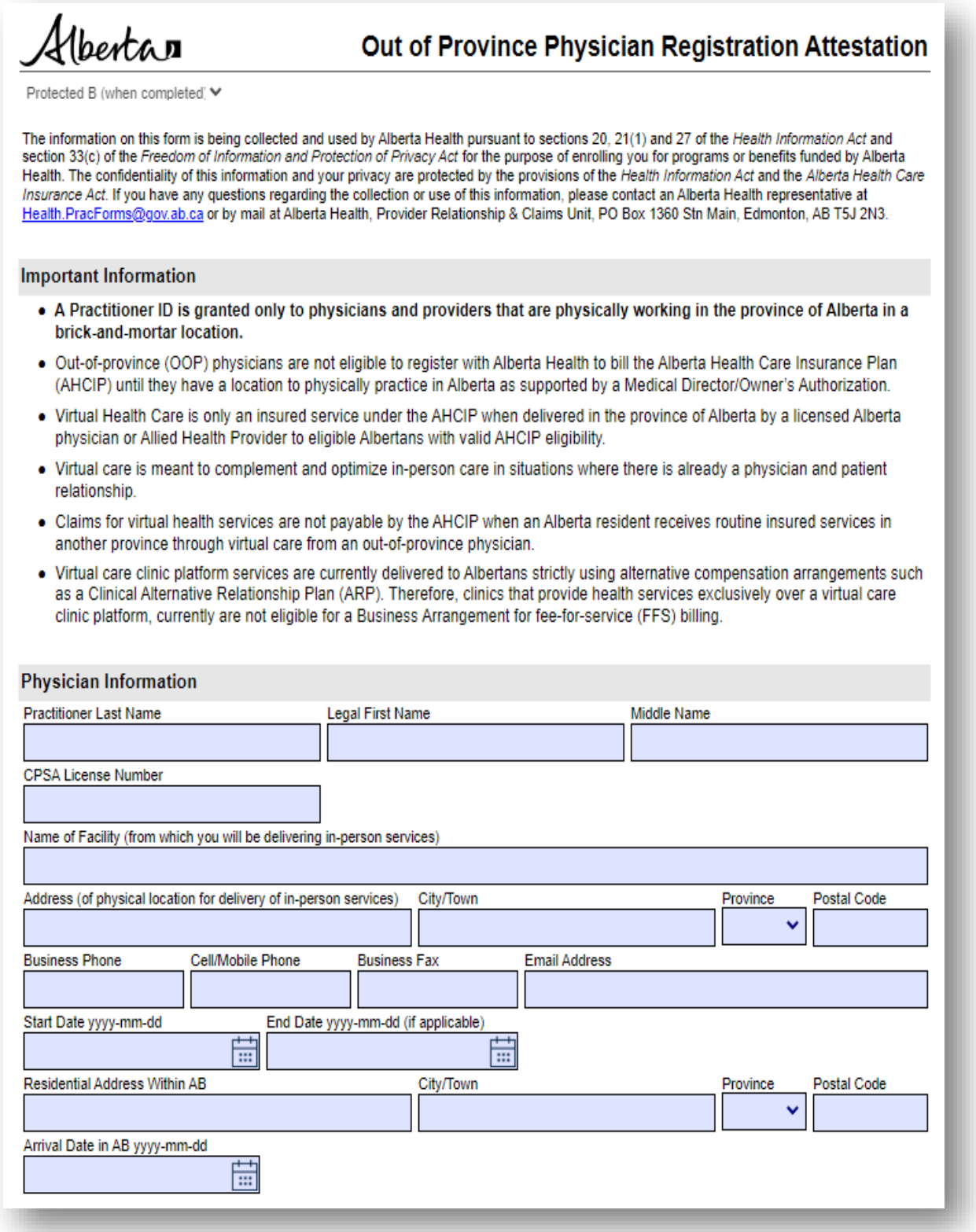
1.5.7 Out of Province Physician Registration Attestation (AHC13398) – Sample



Alberta

Out of Province Physician Registration Attestation

Protected B (when completed)

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

Important Information

- **A Practitioner ID is granted only to physicians and providers that are physically working in the province of Alberta in a brick-and-mortar location.**
- Out-of-province (OOP) physicians are not eligible to register with Alberta Health to bill the Alberta Health Care Insurance Plan (AHCIP) until they have a location to physically practice in Alberta as supported by a Medical Director/Owner's Authorization.
- Virtual Health Care is only an insured service under the AHCIP when delivered in the province of Alberta by a licensed Alberta physician or Allied Health Provider to eligible Albertans with valid AHCIP eligibility.
- Virtual care is meant to complement and optimize in-person care in situations where there is already a physician and patient relationship.
- Claims for virtual health services are not payable by the AHCIP when an Alberta resident receives routine insured services in another province through virtual care from an out-of-province physician.
- Virtual care clinic platform services are currently delivered to Albertans strictly using alternative compensation arrangements such as a Clinical Alternative Relationship Plan (ARP). Therefore, clinics that provide health services exclusively over a virtual care clinic platform, currently are not eligible for a Business Arrangement for fee-for-service (FFS) billing.

Physician Information

Practitioner Last Name | Legal First Name | Middle Name

CPSA License Number

Name of Facility (from which you will be delivering in-person services)

Address (of physical location for delivery of in-person services) | City/Town | Province | Postal Code

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

Start Date yyyy-mm-dd | End Date yyyy-mm-dd (if applicable)

Residential Address Within AB | City/Town | Province | Postal Code

Arrival Date in AB yyyy-mm-dd

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

I, the Practitioner, further certify the truth and accuracy of such information submitted on this registration form, and I acknowledge that I will be practicing in Alberta in order for my registration with the AHCIP to be valid and for the purposes of billing and payment for health services provided to Albertans within the province, false and otherwise incorrect statements on this form may result in my PRAC ID within Alberta to be terminated.

Contact Number | Printed Name

Date yyyy-mm-dd | Practitioner Signature

Medical Director/Owner Authorization - Must be completed for the form to be valid.

I, the Medical Director/Owner, further certify the truth and accuracy of such information submitted on this registration form and I acknowledge that false and otherwise incorrect statements may result in the above Practitioner's PRAC ID within Alberta being terminated.

Contact Number | Printed Name | CPSA License Number (if applicable)

Date yyyy-mm-dd | Medical Director/Owner Signature

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

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1.6 The Business Arrangement

To submit claims for insured services, a physician 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 physician registering with Alberta Health for the first time provides their business arrangement details when they complete the Practitioner Request form – AHC11234.

A physician 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.

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

If a physician 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.

The three types of business arrangements that apply to physicians are:

Fee-for-service:	The traditional method of receiving payment from the AHCIP.
Locum tenens:	A physician who substitutes temporarily for another physician. (Section 1.11 - Locum Tenens.)
Alternate relationship plan:	A mechanism to compensate physicians in a manner other than the traditional fee-for-service method. (Section 1.12 Alternate Relationship Plans)

1.6.1 The business arrangement and the physician's professional corporation

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

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

1.6.2 The business arrangement and the physician's default skill

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

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

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

To ensure accurate validation is in place, physicians are required to complete the Physician Skill Validation form - AHC 13188 and submit the form to Alberta Health's Provider Relationship and Claims Unit to confirm that the physician is qualified, recognized, and certified to perform certain procedures at specific levels within their scope of practice. The Physician Skill Validation form is available on the Government of Alberta website at "Health Professional Business Forms".

Medical directors are fully responsible for reviewing credentials and making decisions on privileging. This includes adhering to any accreditation policies, procedures, and standards.

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

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

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

1.6.4 The business arrangement and the submitter

Claims are sent to the AHCIP via an accredited submitter using the electronic H-Link method. All business arrangements **must** have an accredited submitter attached to them for claims to be submitted for payment. See Section 1.11 - Locum Tenens for more information about locum business arrangements.

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

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

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

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

1.7 Registering Your Facility

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

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

1.8 Changing the Location of Your Practice

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

1.9 Mandatory Address Reporting

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

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

1.10 Buying an Existing Practice or Clinic

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

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

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

1.11 Locum Tenens

When a locum physician comes into a practice to work in place of another physician, the following decisions must be made:

- Whether the claim payments are to be made to the practice's business arrangement number or to the locum's business arrangement number, and
- Whether the claims will be submitted through the practice's submitter or (if applicable) through the locum's submitter.

A physician who wishes to work as a locum tenens must have a locum business arrangement in their own name or in the name of their professional corporation. To obtain a locum business arrangement, complete the Business Arrangement and Relationships Application form – AHC11236.

A locum business arrangement does not need to have a submitter attached in order to submit claims; the locum's claims can be submitted using the submitter of the practice where they are providing the locum. This enables the locum who works in several practices to bill through numerous accredited submitters by applying the appropriate information on the claim.

Depending on the agreement between the practice and the locum physician, four payment options are available for claims paid by the AHCIP. The payment option selected will affect how some fields are to be completed on the locum physician's claims, as described below:

Payment options	Claim field requirements
1. Payment is to be made to the practice using the practice's submitter: **This is the most commonly used option.** Statement of Assessment/Account is forwarded to the practice not the locum.	• Enter the practice's business arrangement number in the Business Arrangement field. • Leave the Locum Business Arrangement field blank.
2. Payment is to be made to the practice using the locum's submitter:	• Enter the practice's business arrangement number in the Business Arrangement field. • Enter the locum's business arrangement number in the Locum Business Arrangement field.
3. Payment is to be made to the locum using the locum's submitter:	• Enter the locum business arrangement number in the Business Arrangement field. • Leave the Locum Business Arrangement field blank.
4. Payment is to be made to the locum using the practice's submitter:	• Enter the locum business arrangement number in the Business Arrangement field. • Enter the practice's business arrangement number in the Locum Business Arrangement field.

When submitting claims for services provided by a locum, the **locum's PRAC ID** must be entered in the PRAC ID field on the claim (to identify the service provider), regardless of which of the above payment options applies. The locum physician must have a locum business arrangement number in order for the claim to be correctly processed.

If using payment option #3 described above, the locum business arrangement will need an accredited submitter. Complete the Business Arrangement and Relationships Application form – AHC11236, with Registration Type as Submitter/Client.

1.12 Alternate Relationship Plans

Physicians may apply for an Alternate Relationship Plan (ARP). ARPs compensate physicians for providing insured medical services in a manner alternative to the traditional fee-for-service method. Currently, there are three types of clinical ARP models available for voluntary adoption: Annualized, Sessional, and the Blended Capitation Model. Alberta Health also provides funding to support academic medicine in partnership with Alberta Health Services, the University of Alberta, and the University of Calgary through the Academic Medicine and Health Services Program. An overview of ARPs is available at https://www.alberta.ca/alternative-relationship-plans.aspx.

For additional information and supports regarding ARPs, physicians may contact the:

- Alberta Medical Association at arpinquiries@albertadoctors.org; or
- Alternative Compensation Delivery Unit at health.arpinfo@gov.ab.ca

1.13 Physicians Opting In and Out of the AHCIP

All physicians who are registered with Alberta Health are deemed to be opted in to the AHCIP unless they take appropriate steps to opt out. Alberta physicians who choose not to participate in the AHCIP must opt out in accordance with the requirements and guidelines set out in the *Alberta Health Care Insurance Act*.

1.13.1 Opted-in physician

An opted-in physician who provides an insured service may not extra-bill the patient. This means they may not bill an amount to the patient that is more than the fee listed in the current SOMB.

There are penalties for physicians who extra-bill. These penalties, which are identified in sections 9 through 15 of the *Alberta Health Care Insurance Act*, include recovery of the amount paid by the AHCIP as well as the amount paid by the patient. The physician may also be liable for a fine.

This link to this legislation can be found online at https://www.alberta.ca/alberta-kings-printer.aspx.

1.13.2 Opted-out physician

By opting out of the AHCIP, a physician, as of the opt-out effective date, is ineligible to make claims for benefits to the AHCIP for providing insured services to patients who have coverage under the AHCIP. Patients who choose to receive physician services from an opted-out physician are responsible for all of the costs charged by the opted-out physician for providing those services. A patient cannot seek reimbursement for these costs from the AHCIP.

A decision to opt out of the AHCIP applies to the physician's personal practice and all business arrangements with Alberta Health of which he is a named member. Where a physician provides surgical services, it is still the case that, notwithstanding a physician's opted-out status, a physician who provides surgical services is still subject to the legislation that governs other related matters such as where surgical services may be provided and in what circumstances an amount may be charged to a patient for those services.

According to the *Alberta Health Care Insurance Act* physicians who want to opt out must take all of the following steps at least 180 days prior to the effective date of opting out:

1. Notify the Minister via the Health Insurance Programs Branch in writing, indicating the effective date of opting out. (See Appendix A for the mailing address.)
2. Publish a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practices.
3. Post a notice of the proposed opting out in a part of the physician's office to which patients have access.

Once a physician has opted out of the AHCIP, they are responsible for the following:

1. Posting a notice in a part of the office where it can be viewed by all patients, advising them of the physician's opted-out status.
2. Ensuring that each patient is personally advised of the physician's opted-out status before any service is provided, and that the patient is fully responsible for all costs of services received and is not entitled to reimbursement by the AHCIP.

In the event that an opted-out physician is the only physician available to provide a service in an emergency, the opted-out physician may bill the AHCIP for providing health services in an emergency. In this situation, the opted-out physician **cannot** charge a patient over and above the amount listed for that service in the SOMB.

The ability of any other opted-in physician to make claims and receive payment under the AHCIP and the AHCIA is unaffected when working alongside an opted-out physician.

Opted Out Physicians requesting a PRAC ID for referral purposes:

Pursuant to General Rule 3.3 in the SOMB, services provided by the opted out physician are deemed to be uninsured and any subsequent services related to the uninsured service provided by the opted out physician would not be eligible for payment under the AHCIP. Therefore, opted out physicians are not eligible for a PRAC ID for referral purposes.

General Rule 3.3 in the SOMB states the following:

"Except for services known to be uninsured, the initial visit(s) to establish a diagnosis of the patient's condition is an insured service, including situations where the patient has been referred to another physician. After establishing a diagnosis during the initial visit(s), if the physician determines the service is not medically required, or is an uninsured service, all subsequent services related to the uninsured service such as preoperative tests, assessments, consultations, surgical procedures, anesthetic or surgical assists may not be claimed."

1.13.3 Opting back into the AHCIP

If an opted-out physician wishes to opt back into the AHCIP, the following criteria apply:

- A physician who has been opted out for **one year or longer** may opt back in by notifying the Minister in writing via the Health Insurance Programs Branch at least 30 days prior to the opt-in effective date.
- A physician who has been opted out of the AHCIP for **less than one year** must apply to the Minister for approval to opt back in. The physician must provide the intended date for opting in, the intended location of practice, the type of insured services that will be provided, and the reason for wishing to opt back in.

Notifications from physicians to opt out and applications to opt back into the AHCIP must be sent to the Minister via the Health Insurance Programs Branch. (See Appendix A – Contact Information and Resources for the mailing address).

Applications from physicians who have been opted out for less than one year and wish to opt back in will be forwarded to the Minister for consideration. Notice of the decision will be sent to the applicant.

2.0 Patient Basics - Eligibility

2.1 Alberta Residents

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

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

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

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

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

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

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

2.2 Confirming Patient Eligibility for AHCIP Coverage

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

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

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

Quebec does not participate in the medical reciprocal program. Physicians should charge patients with active Quebec coverage directly for services performed in Alberta and have the patient complete a Quebec Claim for Physician/Practitioner Services form and submit it directly to the Province of Quebec's provincial health insurance plan – Régie de l'assurance maladie du Québec (RAMQ)

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

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

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

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

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

2.3 Patients who are not Eligible

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

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

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

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

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

Individuals who are not eligible	How to bill
Individuals from another province/territory	• If a patient produces a valid health insurance card from another province/territory where they have coverage, submit a medical reciprocal claim for insured services to Alberta Health. • Patients who cannot provide a valid and active provincial or territorial health insurance card are directly responsible for the cost of the medically required services provided by an Alberta physician. The physician should provide the patient with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 and the patient may submit the claim to their home province's or territory's health insurance plan for reimbursement • You may want to confirm eligibility with the province of origin to ensure payment. (Appendix C – Provincial/Territorial Health Plan Contact Information)
Federal Penitentiary Inmates	• Individuals who are inmates in a federal penitentiary are provided health coverage by the federal government for the period of their incarceration. Medically required services provided to patients in this category should be billed directly to the federal government or other secondary insurer, as applicable. • The AHCIP cannot pay any claims for benefits submitted by physicians for medically required services provided to individuals who are inmates in a federal correction institution when the services were provided. • For medically required services provided to patients in federal penitentiaries, physicians should contact the relevant federal penitentiary and ask to speak to its director of health services, who will provide information concerning how claims are to be submitted and other payment information (i.e., rates).
Members of the Canadian Armed Forces (CAF)	• Members of the CAF are provided health coverage by the federal government until these members are discharged or otherwise leave the CAF. • The AHCIP cannot pay any claims submitted by physicians for medically required services provided to active-duty members of the CAF. • Medavie Blue Cross is currently the federal government's designated administrator responsible for processing claims for medically required services provided to CAF members, including the adjudication and payment of eligible health care provider invoices. Please direct all medical billing for medically required services provided to CAF members to Medavie Blue Cross for processing. For more information about Medavie Blue Cross and how to bill for providing medically required services to CAF members, please refer to their website at: www.medaviebc.ca.
Individuals who have coverage provided by the Province of Quebec	• Currently, the province of Quebec does not have a medical reciprocal agreement with Alberta. Therefore, the AHCIP cannot pay any claims submitted by physicians for medically required services provided to individuals who have public health insurance coverage from the province of Quebec. • In order to be paid for providing medically required services to an individual who has coverage provided by the province of Quebec, the physician or the patient will need to complete a Quebec Claim for Physician/Practitioner Services form found on the Régie de l'assurance maladie du Québec (RAMQ) website and submit the claim directly to Quebec's health authorities for adjudication and payment. • More information can be found in Section 4.4 Types of Claims Excluded from Medical Reciprocal Billing.
Individuals who have chosen to opt out of the AHCIP.	• An individual may choose to declare to the Minister of Health they no longer wish to have coverage under the AHCIP and wish to be opted-out of the AHCIP. • The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an opted-out individual. • In such circumstances, the physician is required to determine the fees payable for the medically required services with the opted-out individual and to bill the opted-out patient directly for the provided services. • Additional Information found in Section 2.4 Patients who Opt Out of the AHCIP.
Non-residents of Canada (e.g. tourists or others not legally entitled to remain in Canada beyond a certain date or time period and are not entitled to study or work in Alberta)	• Non-residents of Canada who are not eligible for AHCIP coverage are individuals who have entered Canada on a tourist visa or other temporary visa that does not allow the visa holder to study or work while in Alberta and requires the visa holder to leave Canada by a set date or set time period. • Non-residents of Canada do not include Ukrainian nationals who are eligible for coverage under Alberta's Ukrainian Evacuee Temporary Health Benefits Program (UETHBP). • The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an individual who is a non-resident of Canada. • In such circumstances the physician will be required to determine the fees payable for the

Individuals who are not eligible	How to bill
	medically required services with the non-resident individual and to bill the non-resident individual directly for the provided services.
Individuals who have unproven coverage from another P/T health insurance plan or who are seeking medically required services in Alberta that are not covered by the MR agreement.	• If a valid and active provincial or territorial health insurance card is not presented, or if the requested medically required service is not eligible under the MR agreement, the physician should bill the patient directly. Patients who cannot provide a valid and active provincial or territorial health insurance card are directly responsible for the cost of the medically required services provided by an Albertan physician. • The physician should provide the patient with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 and the patient may submit the claim to their home province's or territory's health insurance plan for reimbursement.
Temporary residents, such as foreign workers, students and their dependents, who present an Alberta health care card with a past expiry date.	• Individuals who have entered Alberta from outside of Canada with a visa allowing them to temporarily study in Alberta or temporarily work in Alberta for at least 12 months are eligible for AHCIP coverage for the duration of their visa allowing them to study or work remain in Canada. The expiry date of their AHCIP coverage is identified on their Alberta issued health care card. • The AHCIP cannot pay any claims submitted by physicians for medically required services provided to an individual after the expiry date identified on their Alberta health care card. Using the tools/methods described above, check to see if these individuals have a valid and active PHN. If not, bill the patient directly before the medically required service is provided when clinically possible. Patients from outside of Canada are directly responsible for the cost of the medically required services provided. • If a temporary resident is billed and subsequently found to have AHCIP coverage, they can ask the physician to submit a pay to patient claim to Alberta Health for reimbursement.
Individuals who are Ukrainian nationals who have entered or remain in Alberta or Canada due to the armed conflict in Ukraine.	• Evacuees from Ukraine who have entered or remained in Alberta and Canada as a result of the ongoing armed conflict in Ukraine are required to be registered under the Government of Alberta's Ukrainian Evacuee Temporary Health Benefits Program (UETHBP) in order to obtain coverage for medically required services while residing in Alberta. • Once an eligible Ukrainian national is registered in the UETHBP they will be issued a PHN specific to that program. • Alberta Health will pay claims to physicians for medically required services provided to a Ukrainian with a valid and active PHN issued pursuant to the UETHBP. • Where an individual submits a PHN issued per UETHBP, it can be verified using the tools/methods described above. • More information on coverage can be found on the Alberta Health website at: https://www.alberta.ca/support-for-ukrainian-evacuees
Individuals who have entered Alberta and Canada as refugees	• The Interim Federal Health Program (IFHP) provides coverage for individuals who have entered Canada as refugees and are in the process of obtaining refugee status so as to remain in Canada (Refugee Claimants), as well as those individuals who have been denied refugee status (Failed Refugee Claimants), but are appealing the decision. • The AHCIP cannot pay any claims submitted by physicians for medically required services provided to Refugee Claimants and Failed Refugee Claimants.
WCB Patients	• Claims for medically required services provided by a physician to Alberta residents in relation to workplace injuries are not payable by the AHCIP and must be submitted directly to the Workers' Compensation Board (WCB) – Alberta for adjudication and payment. • For more information, see Section 5.8 Workers' Compensation Board (WCB) Claims.

2.4 Patients who Opt Out of the AHCIP

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

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

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

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

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

2.5 The Interactive Voice Response (IVR) System

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

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

To use the IVR system:

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

2.6 Safeguarding Personal Health Cards and Numbers

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

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

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

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

3.0 Claim Submission

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

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

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

The keys to trouble-free claim submissions are:

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

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.

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

3.1 Claim Basics

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

WHO was involved:

Enter:

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

WHAT service was performed:

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

WHERE it occurred:

Enter the facility number.

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

WHEN it occurred:

Enter the date of service.

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

WHY the procedure was done:

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

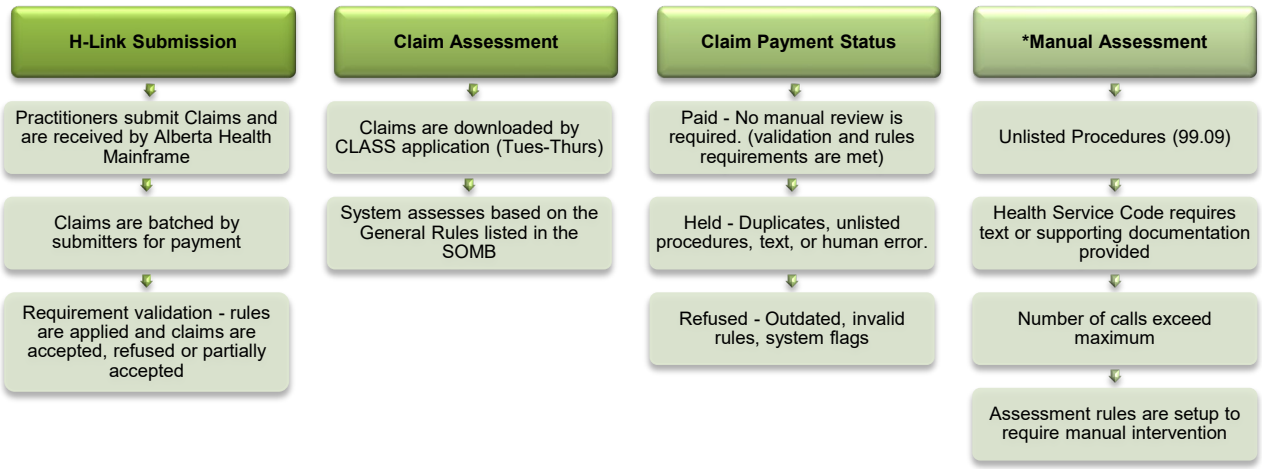
3.2 Claims Processing Overview

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

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

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

- Prior to assessment, the system checks and validates mandatory fields for accurate data.
- The claim is then assessed in accordance with the SOMB and relevant general and assessment rules.
- The claim is then either paid in full, paid at a reduced rate, paid at zero, refused, or held.
- A held claim is assessed manually by a claims adjudicator.
- Once claims have been processed, Alberta Health prepares a Statement of Assessment and sends it to physicians weekly by mail or electronically via their submitter. More information can be found under Section 6.1 Statement of Assessment.



3.3 Claim Processing Timelines

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

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

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

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

All new claims for previous rejected medical reciprocal claims must quote all previously refused claim numbers as Alberta Health cannot trace refused claims using an out of province registration number.

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

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

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

3.4 Outdated Claims

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

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

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

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

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

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

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

3.5 Claims Payment Schedule

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

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

Exceptions to the above payment schedule are:

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

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

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

3.6 Action Codes

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

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

Action code — **When to use**

A (add):

To submit a claim for the first time or to resubmit a claim that was refused (result code RFSE) on the Statement of Assessment. (See Section 6.4 Result codes.)

- Use a new claim number on all action code **A** claims.
- A paid-at-zero claim is **not** the same as a refused claim. If you need to **resubmit a paid-at-zero claim**, use action code **R** (reassess) or **C**

C (change):

To change the information on a claim that appeared on the Statement of Assessment with result code APLY (applied) (See Section 6.4 – Result Codes.)

- Use the same claim number from your Statement of Assessment.
- Include **all** the data from the original submission, but with the required changes. (Leaving a field blank will be recognized as a change.)
- Any new supporting text segment will be added to any earlier text submitted for that claim. (Any supporting text cross-reference segment will be automatically connected to the referenced claims.)
- **Do not** use action code **C** to change any of these details:
  - patient's personal health number
  - physician's PRAC ID
  - business arrangement number
  - locum business arrangement number

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
  - physician's PRAC ID
  - business arrangement number
  - locum business arrangement number
- Then submit a new claim (action code A) with the correct information and a new claim number.
- Pay-to-patient claims **cannot** be deleted.

3.7 Claim Segments

Each claim is made up of four basic segments:

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

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

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

3.7.1 In-province provider base claim segment – CIB1

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

Claim Type: Enter **RGLR** for all actions except for D.

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 physician's PRAC ID. Only the PRAC ID of the physician who provided the specific service is acceptable on the claim for that service.

Skill Code: Physicians who submit claims to the AHCIP have a skill code that identifies the primary skill they use to perform most or all the services for which they will be billing.

Physicians with more than one skill are assigned additional skill codes in accordance with documentation from the CPSA. For certification/skill codes no longer being designated by the CPSA, physicians are now required to complete the AHC 11388 – Physician Skill Validation form. See Section 1.4 Other Forms a Physician May need to Complete.

- When submitting a claim for a service performed using your primary skill, you can leave this field blank providing you have indicated on your business arrangement that this primary skill is your default skill. The processing system will automatically process the claim using your default skill when the Skill Code field is blank.
- If submitting a claim for a service performed using a skill other than your primary skill, enter the other skill code in this field; otherwise, the system will default to the primary skill code and you will be paid the primary skill rate.
- 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 or if it is a first- time claim under the medical reciprocal program, leave this field blank and provide information in the person data segment of the claim. (See Section 3.7.2 - Claim Person Data Segment – CPD1.)

  Once the PHN appears on the Statement of Assessment, enter it on any subsequent claims.

- A PHN is assigned to an out-of-province patient for processing purposes, but it has **no** Alberta eligibility associated with it. (See Service Recipient Other Identifier field.)

Service Recipient Other Identifier:

This field applies to **medical reciprocal claims only**. Enter the health plan registration number for the patient's home province.

- If the patient is a newborn, enter the out-of-province health plan number of the mother/guardian. (See Recovery Code field.)
- This field is **always required** on medical reciprocal claims even though a PHN is assigned to the patient for processing purposes. (See Service Recipient PHN field.)

Health Service Code (HSC):

Enter the appropriate code from the Procedure List in the SOMB.

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

Service Start Date:

Use YYYYMMDD format to enter the date on which the service was performed.

- For hospital visits (HSC 03.03D), 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/Originating Encounter Date field.

- Except for hospital in-patient services, claims may not be submitted more than 90 days from the date of service.

Encounter Number:

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

- Example: Patient is seen by Dr Y at the hospital emergency for a minor leg strain. Later that day, patient returns to emergency and sees Dr Y for a face laceration.
- Most often, the encounter number entered is one (1). An additional separate encounter would be encounter 2 on a separate claim.
- A different encounter number **does not apply** to continuation of services or to services initiated by the physician to a specific patient on the same day. Claims for these services must be submitted with the same encounter number. (See general rule 1.14 in the SOMB.)
- "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 an HSC.

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 HSC submitted will be refused.

Calls:

Enter up to three digits to identify the number of calls for the HSC you are claiming, or the number of units for time-based services you provided.

- Where applicable, the Price List in the SOMB identifies the maximum calls allowed for each HSC, or the number of units for time-based services.
- If the number of services you provided exceeds the maximum specified for that HSC, submit your claim with the actual number of calls plus supporting text or documentation for the claim to be considered for payment. Claims without this information will be automatically reduced to the maximum calls specified in the Price List.

Explicit Fee Modifier:

Modifiers are used in conjunction with the HSC to determine the amount payable. (See Section 3.8 - 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.)
- A facility may have a three-digit number for use on claims for insured services contracted with Alberta Health Services. To ensure the correct facility number is used on a claim to the AHCIP, the physician **must check** with the facility operator to determine if the service is contracted with Alberta Health Services.

Functional Centre:

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

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

Location Code:

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

Originating Facility:

This field is completed in addition to the facility number/location code when service components were performed at two different facilities. Example: when an x-ray is taken in one facility and then interpreted in another facility.

If applicable, enter the facility number where the service originated.

Originating Location:

This field is completed in addition to the facility number/location code when the physician encounters the patient at a location other than where the service occurred and that location is not a recognized facility.

If applicable, enter HOME (for patient's home), or OTHR (other).

Business Arrangement:

Enter the business arrangement number under which the physician is making the claim.

Locums must have their own business arrangement.

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 physician, 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 physician. 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.

Locum Business Arrangement: When a physician performs a service as a locum tenens for another physician, the business arrangement number of the locum physician or the other physician may be entered here, depending on who is to receive payment and which submitter is to be used. (See Section 1.11 - Locum Tenens).

Referral PRAC ID: If the service was provided because of a referral, enter the referring provider's PRAC ID.

- General rule 4.4.8 in the Schedule lists the HSC that require a referral PRAC ID.
- **Do not** enter a professional corporation identifier number in this field or the claim will be refused.
- If the service was referred from an out-of-province provider, leave this field blank. (See Out-of-Province Referral Indicator field.)
- The Practitioner ID Extract Report lists the PRAC ID numbers of health care providers in Alberta who are eligible to refer patients to other practitioners. The report is available electronically on the Alberta Health secure H-Link portal. Refer to Gen Bulletin 81 for more information.

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

- Enter Y if a provider outside Alberta referred the patient for the service. Complete a person data segment for the out-of-province provider.
- **Do not** complete this field on medical reciprocal claims.

Recovery Code: If the claim is a medical reciprocal claim, enter the out-of-province patient's home province recovery code in this field.

Chart Number: This field is reserved for physician 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.

(See Section 3.10 - Submitting Claims for Unlisted Procedures.)

- Claimed amount is not required for other HSC unless you are requesting a lower fee than what is listed in the SOMB.

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.

Additional Compensation (EMSAF Stat):

If the amount is being claimed for additional compensation, as per G.R. 2.6 in the SOMB

- Enter 'Y' in the EMSAF indicator field on your claim.
- Text on the claim must be included with the additional amount being requested over and above the rate that is listed in the schedule.
- Supporting documentation must include:
- A letter explaining why additional compensation is requested, the "Additional Compensation Claim Summary Form" and an operative report if applicable.
    - Total time spent on the procedure describing the added level of complexity, unusual complications or care.
- To request a copy of the "Additional Compensation Claim Summary Form" please email Health.HCIPAProviderClaims@gov.ab.ca.

Confidential Indicator: Enter Y if the patient has asked that a service not be reported on their Statement of Benefits Paid. (See Section 5.5 - Confidential Claims.)

Good Faith Indicator: Enter Y if submitting under the good faith policy. (See Section 5.1 – Billing for Patients who are Unable to Provide a Valid Personal Health Card.)

- You must complete a person data segment for the patient.
- Leave Service Recipient PHN field blank.

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

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

- You must also complete a person data segment for the newborn.
- Once you know the newborn's PHN, you can enter it in the Service Recipient PHN field on any future claims. You will not need a newborn code or a person data segment.
- If this is a medical reciprocal claim and you do not know if the newborn was assigned a PHN for processing purposes, enter the mother's/guardian's out-of-province registration number in the Service Recipient Other Identifier field **and** in the person data segment for the newborn. (See Section 4.0 Medical Reciprocal Billing.)

Paper Supporting Document Indicator: Enter Y if supporting documentation will be sent separately.

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

Hospital Admission Date/ Originating Encounter Date:

This field is used for hospital visits, originating facility encounters and/or periodic chronic care visits, as described below.

Hospital visits:

- When claiming HSC 03.03D, 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 a physician taking over hospital care from another physician (see general rule 4.10 in the SOMB) and claiming for your services, enter the date of the patient's hospital admission in this field.

Originating facility:

- If you have completed the Originating Facility field, enter the date of the originating encounter.

Chronic care visits:

- If you are providing ongoing periodic chronic care visits for a long-term care patient and current service is for palliative care or inter-current illness, use HSC 03.03D and indicate the date on which this care began. (See HSC 03.03E in the SOMB Procedure List.)

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

3.7.2 Claim person data segment – CPD1

This segment must be completed for:

- A patient (RECP) who does not have a PHN or does not know their PHN (See Section 5.1 – Billing for Patients who are Unable to Provide a Valid Personal Health Card.)
- A newborn patient without a PHN. (See Section 5.3 - Newborn claims – Alberta Residents.)
- An out-of-province patient eligible under the medical reciprocal program who has not been assigned an Alberta PHN for processing purposes. (See Section 4.0 Medical Reciprocal Billing.)
- An "other" payee (OTHR); i.e., when someone other than the patient or AHCIP registrant (head of the family) has paid the claim and now wants to be reimbursed.

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

- Be sure to spell the patient's hometown or city correctly and without punctuation, or the claim will be refused.
- Spaces are not required in the postal code field.
- On medical reciprocal claims, provide a completed person data segment until you have a PHN. Once you know the PHN, enter the PHN **as well as** the patient's other province registration number and recovery code on the base claim segment, instead of providing a person data segment.

3.7.3 Claim supporting text segment – CST1

Use this segment only if the claim you are sending requires supporting text. When required, this segment is sent at the same time the base claim segment is submitted. (See Section 3.12 – Submitting Claims with a Gender Restrictions for Transgender Patients and Section 7.5 - Health Service Codes that Require Supporting Text/Documentation.)

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

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

3.7.4 Supporting text cross reference segment – CTX1

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

3.8 Mandatory Claim Fields and Segments

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

If the claim involves	then you must complete this field/segment
• a first-time claim for a newborn:	✔ newborn code ✔ person data segment (including parent/guardian PHN)
• the medical reciprocal program	✔ recovery code ✔ out-of-province registration number ✔ newborn code (if applicable) ✔ out-of-province registration number for mother/guardian of a newborn (if applicable) ✔ person data segment (if PHN is not known)
• good faith	✔ good faith indicator (enter Y) ✔ person data segment
• pay-to code OTHR	✔ pay-to PHN field **or** person data segment
• out-of-province referral	✔ out-of-province referral indicator ✔ person data segment
• confidential claim	✔ confidential indicator (enter Y)

3.9 Modifier Codes

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

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

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

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

1. **Role** – Identifies the physician's function at the time service was provided, e.g., anaesthetist, surgical assistant, etc.

   (When a claim for a surgical procedure is submitted without a role modifier, it is assumed to be the claim from the surgeon.)

2. **Services unscheduled** – Identifies the time block during which a physician provided unscheduled services for a hospital patient (in-patient, outpatient or emergency department).

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 physician or their staff **must not** enter implicit modifiers on claims. Two implicit modifier examples are: 1. **Tray** – A specified amount is automatically added to the base amount on a claim for a procedure entitled to receive a tray fee. 2. **Skill** – When the Skill Code field is left blank, the claim is automatically processed using the default skill indicated on your business arrangement with Alberta Health.

3.10 Claims Reject Due to Patient Eligibility

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

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

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

3.11 Submitting Claims for Unlisted Procedures

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

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

Prior to submitting a claim, you must:

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

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

1. Complete the 99.09 Claim Summary form, available online with the following key information:
    a. The equivalent or comparable service listed in the SOMB, in terms of time, complexity and intensity.

b. Provide rationale to support payment of the claim.

   i. Is the service considered a standard of care or is it experimental?

   ii. Is this service insured in a medical schedule in any other province?

   iii. May this service be incorporated into the clinical practice or is this a one-off service?

2. Attach supporting information, such as an operative report and include the service description, time required, and the amount being requested.

3. Send completed forms and supporting information to the Claims Management Unit via Fax to 780-422-3552 or e-mail to Health.HCIPAProviderClaims@gov.ab.ca.

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

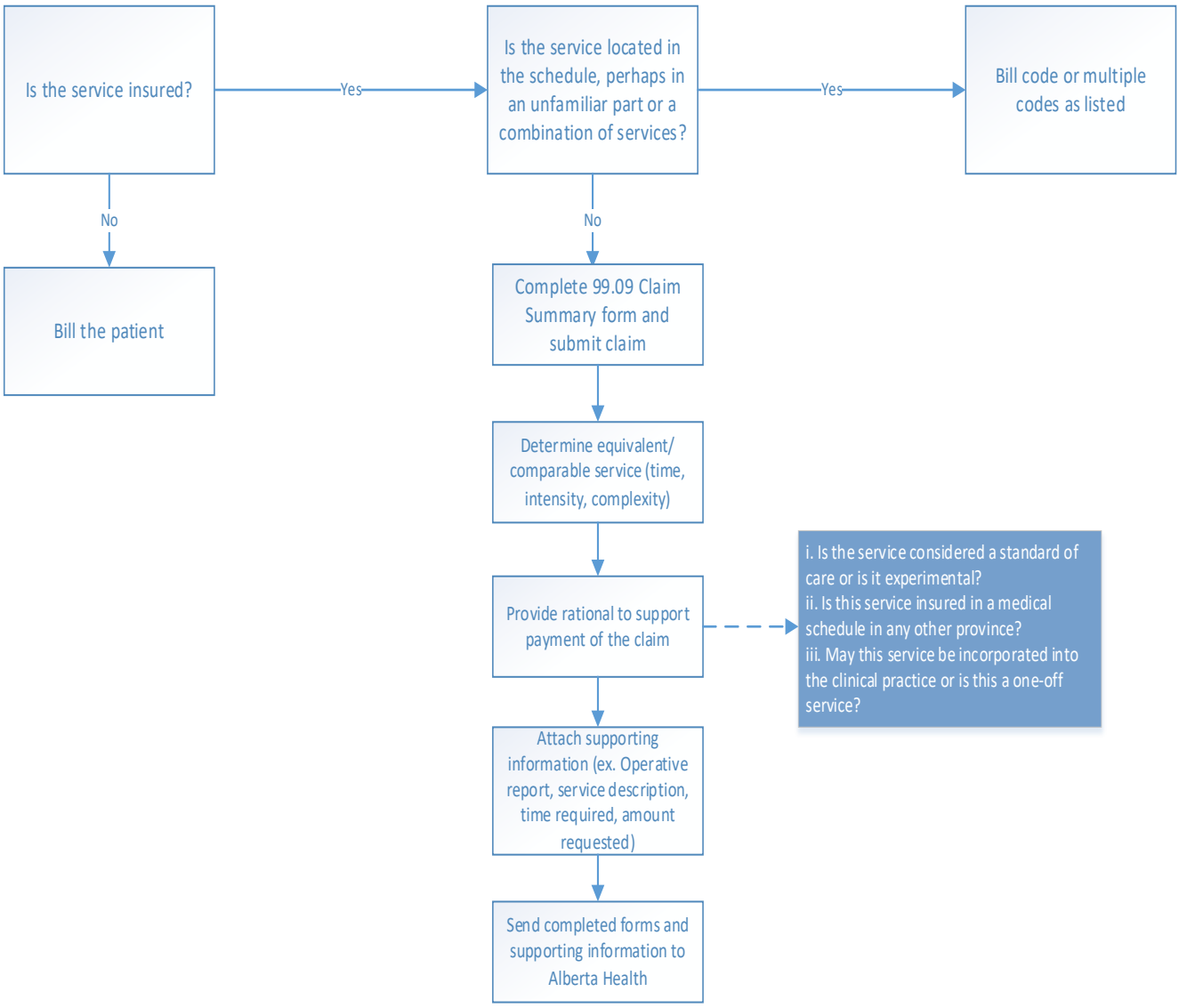
Alberta Health will assess the claim for the unlisted procedure by comparing the service provided and the fee claimed with similar or comparable services listed in the SOMB. The assessment will be based on information concerning the time, complexity, and intensity of the service, as provided in the claim,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

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

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

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

3.11.1 Claims for unlisted procedures submission guide



3.11.2 Additional compensation requests

Additional Compensation (formally known as Extraordinary Medical Service Assessment Fund (EMSAF)) claims are services listed in the SOMB but may require additional compensation due to additional effort required because of the time, intensity, and complexity of the services.

According to Governing Rules 2.6, benefits may be claimed in excess of those listed in the SOMB for services involving unusual complications or care. Due to unusual complications of care and requests for increased compensation, additional documentation, either an operative report or other detailed description of the care is required to support the claim prior to submission.

To submit a claim for additional compensation:

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

2. Consider how much additional compensation you will request.

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

4. Locate the operative report and prepare for faxing.

5. Enter the claim information as usual using the HSC and patient demographic information. Check the EMSAF indicator box of the claim (you may have to contact your software provider to find out where this is located in your program). You will also enter text on the claim that states you are requesting additional compensation for the claim and state the amount you are requesting. If you do not check the EMSAF indicator box, your claim will not enter into the queue for additional compensation.

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

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

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

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

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

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

3.12 Submitting Claims with a Gender Restriction for Transgender Patients

To facilitate physician testing for Sexually Transmitted Blood Borne Infection (STBBI), specifically the use of HSC with a gender restriction, (i.e., pap tests or penile swab) please follow the necessary procedures when billing gender marked services for transgender patients:

- Claim submission of HSC with gender restrictions can be bypassed with the inclusion of text within the claim explaining the patient is transgender. For example, pap test for an individual with an X or M gender marker, or a penile swab for an individual with an X or F gender marker can be billed when the physician submits the claim with text explaining the procedure is for a transgender patient.
- To facilitate medically necessary breast augmentation and medically necessary mastectomy for Alberta transgender patients, and to enable access to these procedures as for cisgender patients, please follow the billing procedures below:

1. Prior to surgery, please contact Alberta Health's Special Programs Unit at 780-415-8744 for validation of eligibility.

2. Complete and sign the Request for Breast Surgery form (AHC12140) that is available on the Alberta Health website and return to the Alberta Health.
    - This form is to be used for eligible Alberta patients diagnosed with gender dysphoria who meet eligibility criteria under the Gender Reaffirming Surgery Program and are seeking breast augmentation or mastectomy surgery.

3. Once approval is received by Alberta Health and following surgery, claims may be submitted for Alberta transgender individuals under HSC 97.43 and 97.22A.

4. The gender restrictions normally present for these billing codes can be bypassed by including text within the claim submission as follows:
    - insert text noting the diagnosis of transgender and,
    - indicate the date of the Alberta Health eligibility prior approval.

Submitting claims with this text will prevent the claim from being rejected by Alberta Health.

4.0 Medical Reciprocal Billing

The *Canada Health Act's* portability provision is implemented through bilateral interprovincial reciprocal billing agreements between provinces and territories that ensure that residents of any province or territory traveling within Canada have access to insured medical and hospital services.

Alberta Health maintains medical reciprocal billing agreements with all provinces and territories except for Québec. When an out of province patient is provided insured health services by an Alberta physician and presents a valid health card from their province of residence, Alberta physicians should submit a medical reciprocal claim.

4.1 Submitting a Medical Reciprocal Claim

Similar to claims for services provided to Alberta residents, medical reciprocal claims are submitted electronically to the AHCIP using H-Link and are assessed and paid at the rates in Alberta's SOMB.

To claim under the medical reciprocal billing agreement:

- The service provided must be insured under the AHCIP.
- The service must not appear on the excluded services list. (See Section 4.3 Exclude Services from Medical Reciprocal Billing.)
- The patient must show you a current health insurance card from their province/territory of residence. (See Appendix D – Valid Provincial/Territorial Health Cards.)

When a physician submits a medical reciprocal claim for a new out-of-province patient, Alberta Health assigns an Alberta PHN to the patient for processing purposes. This PHN has **no Alberta coverage eligibility** associated with it.

The following are two situations for which specific information must be provided on the claim:

1. The physician does not know if the out-of-province patient was previously assigned an Alberta PHN for processing purposes:	**Complete these fields: Base Claim Segment**: ✔ Service recipient other identifier (the patient's home province registration number) ✔ Recovery code (the code for the patient's home province) **Person Data Segment:** ✔ Person type (RECP - service recipient) ✔ Surname ✔ First name ✔ Middle name (if known) ✔ Birthdate (YYYYMMDD) ✔ Gender code (M or F) ✔ Home province address. • Do not use dashes, abbreviations or punctuation, or the claim will be refused. (e.g., 2014 Brookview Crescent Regina SK S3S 4R5)

2. The patient is a newborn whose mother/guardian is an out-of-province resident, and the physician does not know the Alberta PHN assigned to the newborn for processing purposes.	**Complete these fields:** **Base Claim Segment:** ✔ Service recipient other identifier (the mother's/guardian's home province registration number until the newborn receives their own out-of-province registration number) ✔ Recovery code (the code for the patient's home province) ✔ Newborn code - as applicable to the newborn's status: LVBR (live birth), MULT (multiple birth), STBN (stillborn), ADOP (adoption) **Person Data Segment:** ✔ Person type (RECP – service recipient) ✔ Surname ✔ First name (if known) ✔ Middle name (if known) ✔ Birthdate (YYYYMMDD) ✔ Gender code (M or F) ✔ Home province address. Do not use dashes, abbreviations or punctuation, or the claim will be refused. ✔ Parent's/guardian's out-of-province registration number **Claim Supporting Text Segment:** ✔ If the newborn is a twin, triplet, etc., and the first name is not known, include information such as Twin A, Twin B, etc., in this segment of the claim.

Once an Alberta PHN has been assigned to the out-of-province patient for processing purposes, it will appear on the Alberta Health Statement of Assessment. On any future claims for the same out-of-province patient, you can enter the Alberta PHN in the Service Recipient PHN field, their home province health care number in the Service Recipient Other Identifier field, and the applicable province code in the Recovery Code field. You will not need a person data segment on future claims for the patient.

4.2 Medical Reciprocal Billing Tips

The following tips will help you avoid medical reciprocal claim refusals:

- Enter the patient's name on your claim exactly as it is displayed on their health care card.
- Double-check the registration number and province code and ensure they have been entered accurately on the patient's chart and on the claim. For Ontario patients, please omit the 2 letters at the end of the out of province registration number. Refer to the card sample in Appendix D – Ontario.
- Provide all applicable information in the patient's person data segment, including the complete date of birth (YYYYMMDD) and the correct gender code.
- Include text only for "by assessment" claims or when the number of calls for the HSC is greater than the maximum indicated in the Price List of the SOMB.

> When you are referring an out-of-province patient for laboratory services, please be sure to include the patient's health card expiry date on the laboratory requisition form if it is available. In situations where the laboratory needs to refer a specimen on to a hospital for testing, the hospital requires the card expiry date in order to submit a hospital reciprocal claim to the AHCIP for their services.

4.3 Excluded Services from Medical Reciprocal Billing

Not all services are insured in every province or territory and are therefore excluded from the medical reciprocal billing agreements. The services listed below are currently excluded from medical reciprocal billing. When these services are provided to out of province patients by an Alberta physician, bill the patient directly and the patient can submit a claim to their provincial/territorial health plan when they return home.

- Cosmetic surgery for alteration of appearance
- Virtual Care (HSC: 08.19CW, 08.19CX, 08.19CV, 03.01AD, 03.03CV,
- 03.03FV and 03.08CV)
- Sex-reassignment surgery
- Surgery for reversal of sterilization
- Routine periodic health exams, including any routine eye exams
- Telemedicine
- In-vitro fertilization or artificial insemination
- Lithotripsy for gallbladder stones
- Treatment of port-wine stains on other than the face or neck, regardless of method of treatment
- Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- Services to persons covered by other agencies; Canadian Forces, WCB, Veterans Affairs Canada, Correctional Service of Canada, etc.
- Services requested by a third party (e.g., driver's licence medical, employment medical)
- Team conference(s) (HSC: 03.05JA, 03.05T, 03.05U, 03.05V, 03.05W, 03.05Y, 08.19F, 08.19H, 08.19J, 08.19K)
- Evidence from a psychiatrist at a Review Panel (HSC 08.11B)
- Genetic screening and other genetic investigation, including DNA probes.
- Procedures still in the experimental/developmental stage
- Anaesthetic services and surgical assistant services associated with any of the above

4.4 Types of Claims Excluded from Medical Reciprocal Billing

- Claims for Quebec residents cannot be submitted to the AHCIP, as Quebec does not participate in interprovincial medical reciprocal billing. (See Section 2.3 – Patients who are not Eligible)
- WCB claims, including claims for out-of-province patients working in Alberta, must be submitted directly to the WCB (See Section 2.3 – Patients who are not Eligible and Section 5.8 – Workers' Compensation Board (WCB) Claims).
- Confidential claims should be submitted to the patient's home province health plan for payment or billed to the patient. (See Section 5.5 - Confidential Claims.)

5.0 Special Situations

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

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

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

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

5.1.1 Submitting a claim

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

Please refer to the H-Link specification while highlighting the Good Faith Indicator field; set to "Y" and leave the PHN field blank. On your claim complete the following with the identified information:

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

2. CPD1 – Person data segment which must contain:
   - Patient demographic information collected from the patient as follows such as Surname, First Name, Date of Birth, Gender, and complete Address including postal code.
   - Attach a person data segment and enter the personal information collected from the patient, including their name and address.

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

5.2 Claims for Services Provided to Out-of-Province Patients

Claims for services provided to out-of-province patients who are eligible for coverage under another provincial or territory must be submitted as a medical reciprocal claim (See Section 4.0 Medical Reciprocal Billing.)

5.2.1 Out-of-province patient eligibility

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

> Quoting a number without presenting a card is not acceptable. **Physician 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 physician offices, hospital/clinics with patient's out-of-province health care numbers. Refer to Section 2.2 – Confirming Patient Eligibility for AHCIP Coverage for billing options if a valid health insurance card is not presented.

The recovery codes, if applicable, and samples of all province/territory health cards are displayed in Appendix D. If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office (See Appendix C – Provincial/Territorial Health Plan Contact Information) to resolve any beneficiary entitlement concerns.

5.2.2 Billing for services provided to an out-of-province patient

There are three ways an Alberta physician can bill for patients who are from outside Alberta:

1. Submit a claim to the AHCIP for processing through the medical reciprocal program. To do this, **you must see** the patient's provincial health care card. (See Section 4.1 – Submitting a Medical Reciprocal Claim).

2. Quebec does not participate in the medical reciprocal program. Physicians should charge patients with active Quebec coverage directly for services performed in Alberta and have the patient complete a Quebec Claim for Physician/Practitioner Services form and submit it directly to the Province of Quebec's provincial health insurance plan – Régie de l'assurance maladie du Québec (RAMQ)

3. 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 physician's office as a record of payment.

> Patients who cannot provide a valid health card are directly responsible for the cost of the services provided. **Quoting a number without presenting a card is not acceptable. Physician offices/hospitals must see the patient's current card and information on each visit. Using the patient's information already on file is not acceptable.**
>
> Patients may seek reimbursement for the payment of insured health services from their province/territory of residence.

4. If the above is not possible at the time of service, physicians or their staff must email healthpcsp.admin@gov.ab.ca and Alberta Health will provide written instructions on how to submit a claim to the AHCIP for payment.

Billing the patient directly **should not be a replacement** for reciprocal billing but **should only serve as an option** in instances where a valid health insurance card is not presented at the time of service, or if the patient is from Quebec.

If billing the patient directly, the physician 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.

5.3 Newborn Claims – Alberta Residents

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

Base claim segment:

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

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

Person Data segment:

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

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

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

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

5.4 Virtual Health Claims

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

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

Alberta physicians are allowed to submit claims for services eligible through virtual means when outside Alberta (both within Canada and outside Canada). However, the intent of this rule is to only facilitate provision of care where there is already a physician and patient relationship or there is a need for urgent care advice. A physician should be able to demonstrate why the service was provided from outside Alberta.

As virtual care services are excluded from reciprocal billing, out-of-province patients are responsible for the cost of virtual health services provided by Alberta physicians and can submit a claim directly to their provincial health plan for possible reimbursement. Out of province patients should consult with their provincial health care plan to confirm that virtual care health services are covered when performed by an Alberta physician.

5.5 Confidential Claims

Alberta residents can request a Statement of Benefits Paid from Alberta Health. The statement itemizes payments made by the AHCIP on the patient's behalf for insured practitioner services.

If the patient does not want a particular service to be shown on the Statement of Benefits Paid, enter "Y" in the Confidential Indicator field on the claim. (See Section 3.7.1 - In-Province Provider Base Claim Segment - CIB1.)

This must be done by the **physician/billing staff**, as Alberta Health does not accept requests from **patients** to remove confidential services from the Statement of Benefits Paid.

Some examples of services a patient may not want to appear on their Statement of Benefits Paid are:

- Substance abuse treatment
- Gynaecology services
- Psychiatric services
- Sexual assault treatment
- Sexually transmitted disease treatment

Alberta Health cannot guarantee that a confidential claim submitted under the medical reciprocal program will be identified as such by the patient's home province, as other provincial health plan systems may not interpret the confidential indicator on claims submitted to them.

All confidential claims for residents from other provinces should be submitted directly to the patient's home province health plan or billed to the patient.

5.6 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 SOMB General Rule 3.1(l).

5.7 Sexually Transmitted Infection Claims

Physician claims for sexually transmitted infections must be submitted to Alberta Health Services if the patient is:

- Not eligible for AHCIP coverage, or
- A transient, refugee, etc., or
- Not eligible under the medical reciprocal program, or
- A resident of Quebec, or
- A non-Canadian unable to pay for the service.

Submit a paper claim to Alberta Health Services at the address below:

Sexually Transmitted Infections (STI) Services
Alberta Health Services
2nd floor South Tower
10030 – 107 Street NW
Edmonton AB T5J 3E4

Alberta Health Services will **only** accept claims that are **not eligible for AHCIP processing**. These payments do not appear on the physician's Statement of Assessment or the patient's Statement of Benefits Paid.

5.8 Workers' Compensation Board (WCB) Claims

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

> 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. Physicians can also contact the WCB eBusiness Support Team at 780-498-7688 or the WCB Claims Contact Centre toll-free at 1-866-922-9221.

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

Physicians 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, physicians should submit a "delete" claim (action code D) to reverse the claim. For assistance in submitting a "delete" claim, please refer to Section 3.6 – Action Codes.

> Alberta Health regularly reviews practitioner claims to identify and recover funds where 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 HSC 03.01J.

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

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

5.9 RCMP Member Claims

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

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

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

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

Claims for services provided to RCMP members who are residents of the other Canadian provinces and territories (except Quebec) will be eligible for payment under the medical reciprocal program.

5.10 Medical Assistance in Dying (MAID)

All physician claims submitted for providing health services for Medical Assistance in Dying will be paid by Alberta Health according to the following process:

- For billing purposes, Alberta Health Services' classification of Medical Assistance in Dying into the following phases has been adopted and is described as follows:
  - Pre-contemplation phase
  - Contemplation phase
  - Determination phase
  - Action phase
  - Care After Death phase

- Medical Assistance in Dying provided during the pre-contemplation and contemplation phases may be billed using existing HSC, such as visit, team conference, or consultation codes, through the SOMB. The contemplation phase ends when one assessment of eligibility for Medical Assistance in Dying is completed.
- For all services provided during the determination phase, physicians should bill 03.7 BA.
- For all services provided during the action phases, physicians should bill 03.7 BB.
- For all services provided during the care after death phases, physicians should bill 03.7 BC.

- After the contemplation phase, no services related to Medical Assistance in Dying may be billed. Concurrent claims for overlapping time for the same or different patients may not be claimed.
- If a patient chooses to withdraw his or her request for Medical Assistance in Dying or to pause the process for any reason at any point in the process, a physician may still claim for any related services provided to the patient up until the patient's decision.

Physicians providing Medical Assistance in Dying must follow the College of Physicians and Surgeons of Alberta (CPSA) Standards of Practice for Medical Assistance in Dying. These Standards can be found at https://cpsa.ca/wp-content/uploads/2022/11/Consultation-025-MAID-clean.pdf.

For information on Alberta Health Services' classification of the phases of Medical Assistance in Dying, and Alberta Health Services' comprehensive clinical guide for detailed processes, visit www.AHS.ca/MAID.

For additional information on the MAID HSC and pricing, please see the Schedule of Medical Benefits and any updates made to the schedule will be listed in the Medical Bulletin

- Medical Bulletin: https://www.alberta.ca/bulletins-for-health- professionals.aspx
- SOMB: https://www.alberta.ca/fees-health-professionals.aspx

5.11 Physicians in Lloydminster Billing the AHCIP

Lloydminster physicians with permanent medical practices on both sides of the Alberta and Saskatchewan border are eligible to establish business arrangements (BA) with Alberta Health if the College of Physicians and Surgeons of Alberta, or the College of Physicians and Surgeons of Saskatchewan, indicate their license is active. These BA's allow physicians to submit claims for services they provide to

Albertans directly to the AHCIP and to be paid at Alberta rates.

Physicians based in Lloydminster, Saskatchewan **can only bill** Alberta Health for services provided to Alberta residents. Health services provided to Saskatchewan residents **must** be billed to the Saskatchewan Provincial Health Plan.

The AHCIP compensates providers in accordance with the SOMB. Under the AHCIP, claims are paid to providers once claims are submitted, received and processed. To ensure accountability of the AHCIP, the department monitors the health care providers' claims through regular reviews to ensure billing practices are compliant with the respective legislation and agreements (See Section 6.9 - Monitoring and Compliance)

5.12 Health Care Services Provided to Albertans Elsewhere in Canada

When an Alberta physician refers an Alberta patient to another Canadian province to receive insured services, prior approval for funding of those services is not required from Alberta Health. These services will be billed according to the interprovincial reciprocal billing process.

Alberta has reciprocal agreements with all provinces and territories for insured hospital services, and reciprocal agreements with all provinces and territories, except Quebec, for insured physician services.

Alberta Health recommends that before any elective health services, whether in a publicly funded facility or private facility, outside Alberta are booked, that Albertans speak to the facility where they are having their surgery to clarify what will be billed reciprocally to the AHCIP and what they can expect to pay.

5.12.1 Requesting funding prior-approval for out of province medical services

For services not covered under the reciprocal agreements, funding may be sought through Alberta Health. A funding request letter must be submitted by the referring Alberta physician on behalf of the eligible Alberta patient. Alberta Health does not accept funding requests from OOP health service providers, on behalf of an Alberta patient.

The following information must be included in the funding request letter to assist Alberta Health in evaluating the request:

- Patient name, birth date, address, personal health number.
- Indication the therapy is the established standard of care and treatment has been approved by Health Canada, if relevant.
- Confirmation the treatment is a publicly funded/ insured service and not considered experimental or part of a clinical trial.
- Date of treatment, OOP facility name
- Confirmation of capacity at OOP facility.

- Identification if alternative treatments are available and have been explored in Alberta;
- Confirmation that the referral is supported by the AHS.
  - A physician must first work with relevant AHS clinical (Clinical departments/ tumour boards etc.), and administrative leaders (respective Zone Operational and Medical leadership) to ensure the request for the OOP service is supported by the health authority and is confirmed to be not available in Alberta.
- Identification of follow-up care that is available and provided in Alberta, and
- If possible, costing information and information from the out-of-province facility regarding how the costs will be billed.

Following receipt of this information, Alberta Health will review the funding request and notify the referring physician in writing of its decision. To facilitate the process, the referring physician's contact information must clearly note cell phone and email to assist with the review and ease of contact should questions arise.

Following physician notification of funding pre-approval, it is the responsibility of the physician for all aspects of case management including arranging for the patient's admission and treatment with the OOP facility, patient travel plans, discharge, and follow up. Alberta Health is not responsible for patient case management.

Requests for funding for the cost of a procedure, or questions regarding funding for procedures outside of Alberta, can be e-mailed to the Out-Of-Province Claims unit at Health.HCIPAOOPOOC@gov.ab.ca. When submitting a funding request to Alberta Health, please ensure the subject line of your e-mail clearly identifies that you are requesting funding approval for the cost of an OOP procedure.

5.12.2 Alberta Health's gender surgery program

Under the Gender Surgery Program, funding is available for eligible Alberta residents who meet established program criteria to receive phalloplasty, metoidioplasty or vaginoplasty.

Specific criteria must be met for a patient to be considered for funding under the Gender Surgery Program. Patients must undergo two independent assessments by psychiatrists or physicians with extensive training or clinical experience in assessing and managing the mental health needs of the transgender population and be diagnosed with gender dysphoria.

The Gender Surgery Program does not provide funding for:

- Services provided outside of Canada.
- Cosmetic procedures that are not deemed medically necessary, such as facial feminization, tracheal shave and voice pitch surgery.
- Non-medical interventions required prior to gender surgery, such as electrolysis, laser hair removal or massage therapy; or
- Any other additional costs such as take-home medications, equipment, meals, accommodations and other personal expenses.

For further information, please contact the Special Programs Unit at health.oochsc@gov.ab.ca.

5.13 Health Care Services Received by Albertans Outside Canada

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

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

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

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

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

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

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

Eligibility

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

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

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

Applications can be submitted by mail to:

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

Or by email: health.oochsc@gov.ab.ca.

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

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

Appeals

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

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

Information about the Appeal Panel is available by calling 780-638-3899 in Edmonton, or toll-free by dialing 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

5.13.2 Partial AHCIP coverage

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

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

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

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

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

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

6.0 Reviewing & Reconciling Claim Results

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

6.1 Statement of Assessment

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

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

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

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

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

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

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

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

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

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

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

If you require copies of the Statement of Assessment outside 30 weeks of the issue date you must complete and submit the "Request for Statement of Assessment/Account" form (AHC0002) .

Alberta health must be notified of any changes to your business mailing address, as this highly impacts the mailing out of your week Statement of Assessments.

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

6.2 Statement of Assessment – Sample

SE400RS3 REL #: 0006056

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

4 Statement Date: 2023/06/23
Page 1

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

STATEMENT OF ASSESSMENT

5
Reference Nbrs
297535021

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

6
Sequence Nbr
2

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

6.3 Statement of Assessment – Field Descriptions

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

1. **Statement of Assessment Addressee**
   Name and address of the person or organization designated to receive this statement.

2. **Business Arrangement**
   Number indicating which business arrangement is to be paid.

3. **Expected Payment Date**
   Date on which payment will be issued.

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

5. **Reference Numbers**
   ID number assigned to the Statement of Assessment produced.

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

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

8. **Practitioner Identification Number (PRAC ID)**
   Unique number identifying the service provider.

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

10. **Chart Number**
    Source reference number provided on the claim transaction by the physician.

11. **PHN**
    Personal health number identifying each patient.

12. **Claim Number**
    Number assigned to each claim by the submitter.

13. **Service Start Date**
    Date the service was performed, started or received.

14. **Service Code**
    Unique code identifying the health service provided.

15. **Claimed Amount**
    Amount claimed for the service provided.

16. **Assessed Amount**
    Amount paid after application of assessment rules and other criteria.

17. **Modifier Code**
    Explicit modifier code(s) affecting payment of a HSC.

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

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

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

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

6.4 Result Codes

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

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

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

   If you need to correct the data on a paid-at-zero claim or if you disagree with the reason why the claim was paid at zero, you must resubmit the claim with action code C (change) or R (reassess), as applicable. (See Sections 3.6 - Action Codes and 6.5 - Following up on a Claim – Using the Correct Action Code.)

2. **RFSE** (Refuse) means the claim transaction was refused. This is usually due to invalid or missing claim data (such as the patient's PHN); however, it may be refused for some other reason, such as a general rule or note in the SOMB, 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 3.6 - Action Codes and 6.5 - Following up on a Claim – Using the Correct Action Code on a Claim – Using the Correct Action Code.)

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

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

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

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

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

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

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

6.6 Statement of Account

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

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

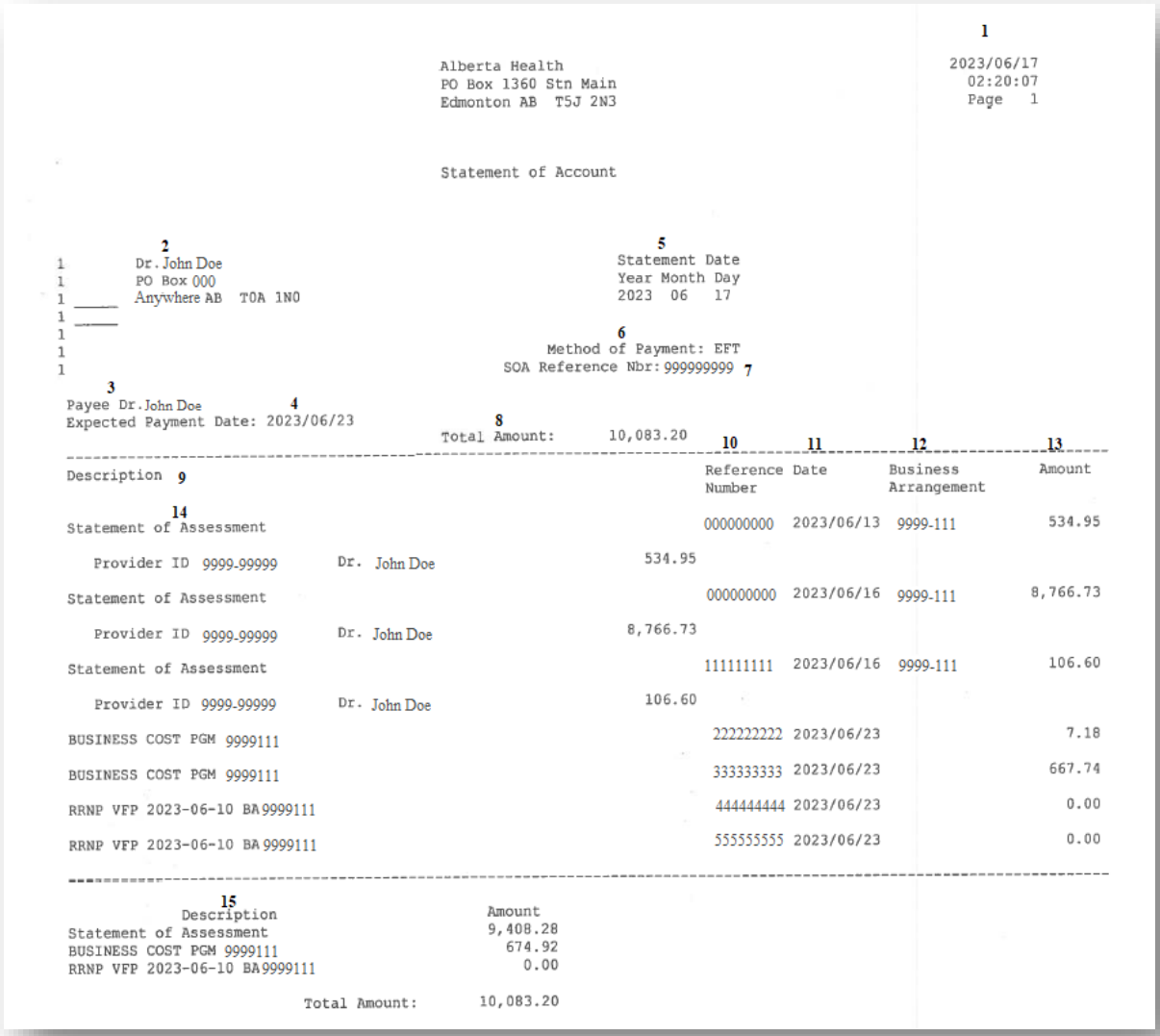
It is your responsibility to retain all Statements of Account until you have completed your reconciliations, no longer require them for tax purposes and have met the requirements in Section 15(2) of the *Alberta Health Care Insurance Regulation* which states that **billing information must be kept for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

If a copy of the Statement of Account is required you must complete and submit the Request for Statement of Assessment/Account form AHC0002 (Appendix A.1 Additional Alberta Health Contact Information).

Alberta Health will not provide copies of the Statement of Account unless the requester can **provide evidence** that the Statement of Account is no longer in their custody or control due to extenuating circumstances. This includes destruction or loss through fire, flood, natural disasters or the theft of paper copies, or the computer where electronic copies were stored.

In all cases Alberta Health will determine whether copies shall be provided and the time period for which the copies will be provided.

6.7 Statement of Account - Sample



1

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

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

Statement of Account

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

5
Statement Date
Year Month Day
2023 06 17

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

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

8
Total Amount: 10,083.20

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

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

6.8 Statement of Account – Field Descriptions

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

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

6.9 Monitoring and Compliance

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

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

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

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

- Extrapolation of the results from the sample to the population of paid claims in the review period. This compliance review is an interactive and administratively fair process through which providers have the opportunity to provide documentation and comments including a response to the compliance review findings. The compliance review process includes:
  - Notice of compliance review;
  - Submission of patient records and documentation by the provider;
  - Review of claims and documentation by the Compliance and Monitoring Branch;
  - Notice of Findings issued by the Compliance and Monitoring Branch;
  - Response submitted by the provider and subsequent review;
  - Notice of Reassessment issued by the Health Protection Branch;
  - Recovery of any overpayments determined by the Health Protection Branch or appeal avenues pursued by the Provider.

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

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

Documentation in patient health records must be completed in a manner deemed acceptable by the Minister. Alberta Health recognizes the College of Physicians and Surgeons of Alberta Patient Record Content Standard of Practice, as updated from time to time, as the minimum level of evidence to support a practitioner's claims for benefits under the AHCIP.

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

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

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

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

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

7.0 Schedule of Medical Benefits (SOMB)

The *Alberta Health Care Insurance Act* stipulates that the Minister of Health must provide insurance coverage for basic health services for all eligible residents of Alberta. Insured services include all services provided by physicians that are medically required, a standard determined by a physician's professional judgment and the standards of practice of the College of Physicians and Surgeons of Alberta.

The descriptions of insured medical services provided to residents of Alberta set out in the SOMB, which can be found online at https://www.alberta.ca/fees-health-professionals.aspx. Physician claims are assessed in compliance with General Rules set out in the SOMB and specific payment notes attached to individual HSC.

The SOMB is updated periodically, physicians are encouraged to check the Alberta Health website regularly to ensure they are using the most recent edition of the Schedule for their claim submissions.

The SOMB consists of the following sections:

General Rules	Defines the circumstances under which insured services are paid.
Procedure List	Lists insured diagnostic, therapeutic and surgical procedures. This section contains HSC and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.
Price List	Lists all HSC and their applicable modifiers. This section indicates how fees are modified by specific circumstances. It displays the category code for each service so physicians 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.
Anaesthetic Rates Applicable to Dental Services, Podiatry Services and Podiatric Surgery	Contains procedure and price list information for use by physicians who provide anaesthetic services for insured dental, podiatry and podiatric surgery services.

7.1 Procedure List

This component of the SOMB lists all insured visits, procedures and tests in numerical HSC order followed by laboratory/pathology (E- and F-prefix codes) and diagnostic/therapeutic radiology (X- and Y-prefix codes) services. Its table of contents provides the headings and numbers by anatomical region and specifies the page for each HSC.

To help you understand how the Procedure List works, please refer to the sample page that appears on the next section of this guide. The main elements have been numbered on the sample. Match the numbered elements with the explanations given below.

1. Roman numerals and general heading for the particular section, e.g., I. CERTAIN DIAGNOSTIC AND THERAPUETIC PROCEDURES.

2. This field identifies the section heading.

3. The HSC for the service performed.

4. A description of the HSC.

5. The NOTE field contains special instructions for a HSC.

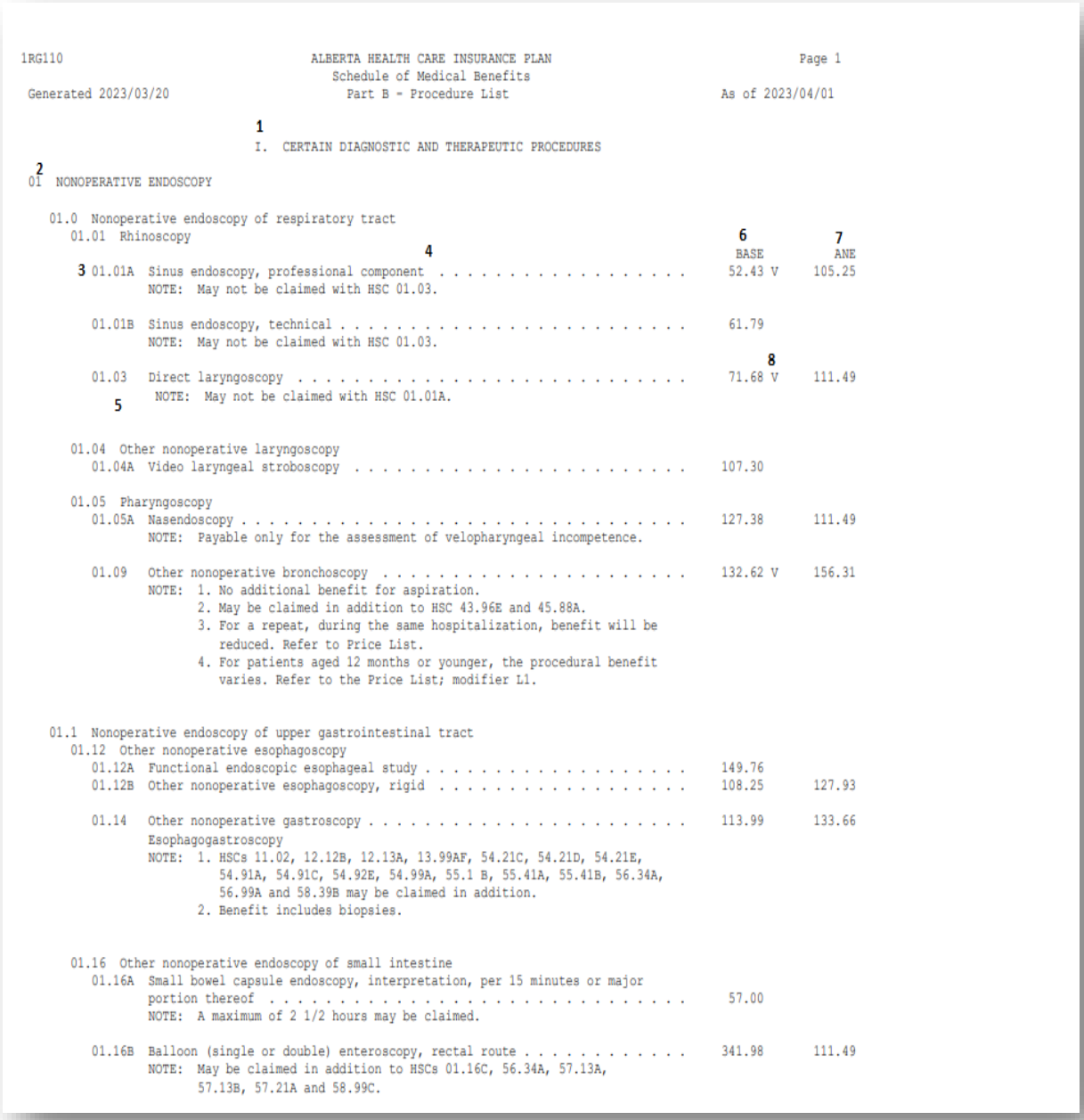
6. BASE amount is the fee for the service before application of any modifiers. This may be a dollar amount or the code BY ASSESS.

7. The ANE field indicates the anaesthetic fee for the service.

8. The letter V beside the base rate means the fee payable varies depending on the physician's skill and/or specific modifiers associated with the HSC.

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

7.2 Procedure List – Sample Page



1RG110 ALBERTA HEALTH CARE INSURANCE PLAN Page 1
Schedule of Medical Benefits
Generated 2023/03/20 Part B - Procedure List As of 2023/04/01

1
I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES

2
01 NONOPERATIVE ENDOSCOPY

01.0 Nonoperative endoscopy of respiratory tract
01.01 Rhinoscopy

4 6 BASE 7 ANE

3 01.01A Sinus endoscopy, professional component . . . . . 52.43 V 105.25
NOTE: May not be claimed with HSC 01.03.

01.01B Sinus endoscopy, technical 61.79
NOTE: May not be claimed with HSC 01.03.

8
01.03 Direct laryngoscopy . . . . . 71.68 V 111.49
5 NOTE: May not be claimed with HSC 01.01A.

01.04 Other nonoperative laryngoscopy
01.04A Video laryngeal stroboscopy 107.30

01.05 Pharyngoscopy
01.05A Nasendoscopy 127.38 111.49
NOTE: Payable only for the assessment of velopharyngeal incompetence.

01.09 Other nonoperative bronchoscopy . . . . . 132.62 V 156.31
NOTE: 1. No additional benefit for aspiration.
2. May be claimed in addition to HSC 43.96E and 45.88A.
3. For a repeat, during the same hospitalization, benefit will be reduced. Refer to Price List.
4. For patients aged 12 months or younger, the procedural benefit varies. Refer to the Price List; modifier L1.

01.1 Nonoperative endoscopy of upper gastrointestinal tract
01.12 Other nonoperative esophagoscopy
01.12A Functional endoscopic esophageal study 149.76
01.12B Other nonoperative esophagoscopy, rigid 108.25 127.93

01.14 Other nonoperative gastroscopy 113.99 133.66
Esophagogastroscopy
NOTE: 1. HSCs 11.02, 12.12B, 12.13A, 13.99AF, 54.21C, 54.21D, 54.21E, 54.91A, 54.91C, 54.92E, 54.99A, 55.1 B, 55.41A, 55.41B, 56.34A, 56.99A and 58.39B may be claimed in addition.
2. Benefit includes biopsies.

01.16 Other nonoperative endoscopy of small intestine
01.16A Small bowel capsule endoscopy, interpretation, per 15 minutes or major portion thereof 57.00
NOTE: A maximum of 2 1/2 hours may be claimed.

01.16B Balloon (single or double) enteroscopy, rectal route 341.98 111.49
NOTE: May be claimed in addition to HSCs 01.16C, 56.34A, 57.13A, 57.13B, 57.21A and 58.99C.

7.3 Price List

This component of the SOMB displays the base fee for the different HSC, as well as modifier definitions arranged by type, code and description. All the numeric HSC appear first, followed by the laboratory/pathology (E- and F-prefix codes) and diagnostic/therapeutic radiology (X- and Y-prefix codes) service codes.

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

1. Description: Non operative Endoscopy is the section heading.

2. 01.01A is the HSC. See the Procedure List for a description of this code.

3. $52.43 is the base fee for this procedure.

4. This field lists all modifier types that apply to this HSC. (01.01A has fifteen applicable modifier types.)

5. A listing of all modifier codes that affect payment, applicable to this HSC.

6. A ROLE modifier code entered on a claim indicates the function performed by the physician in providing the service.

7. The modifier codes (1, 2-150) associated with modifier type ANU indicate the maximum number of services that may be claimed by a physician using role modifier ANEST. (Supporting text is required if this maximum is exceeded.)

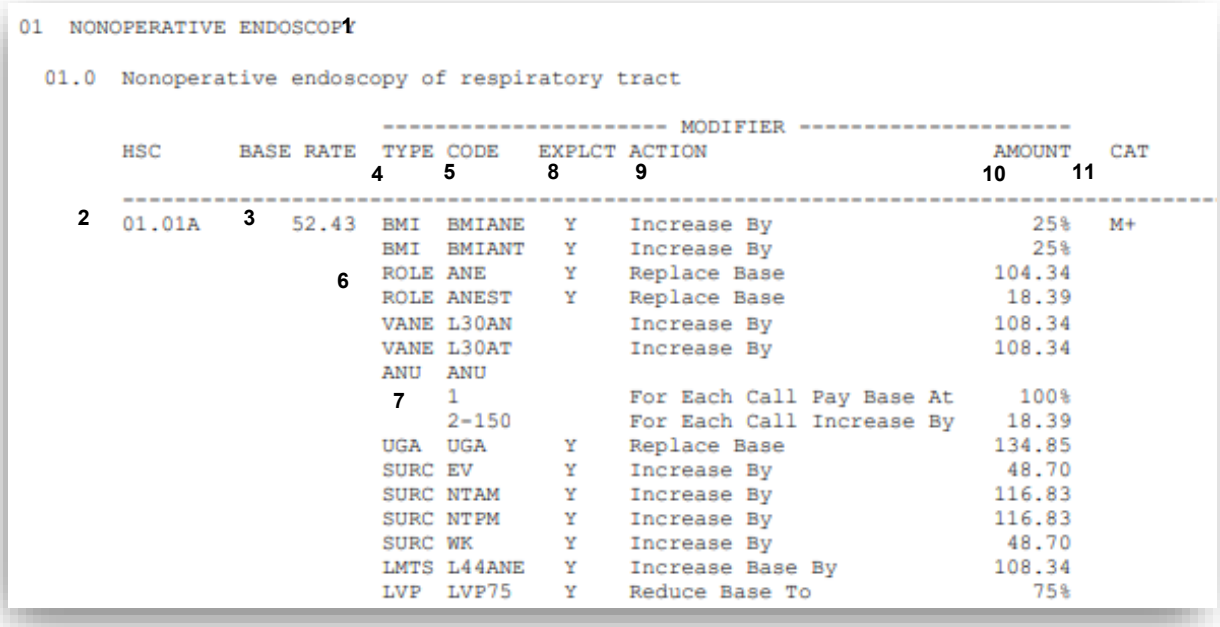
8. The letter Y in this field identifies each explicit modifier. When applicable, these must be entered on a claim prior to submission.

9. This field shows what effect the modifier has on the base amount. Example: When role modifier ANE is entered on a claim for HSC 01.01A, the base amount is replaced by the amount in the next column.

10. This field indicates the fee for each modifier code. Example: The ANE fee for HSC 01.01A is $104.34.

11. The category code for each HSC. For example, the letter M+ identifies as a diagnostic whereas M is for therapeutic or prophylactic reasons. If a minor procedure (M or M+) is provided with a hospital visit on the same day, only the greater benefit HSC may be claimed.

7.4 Price List – Sample Page



01 NONOPERATIVE ENDOSCOPY (1)

01.0 Nonoperative endoscopy of respiratory tract

(2) HSC	(3) BASE RATE	(4) MODIFIER TYPE	(5) MODIFIER CODE	(8) EXPLCT	(9) MODIFIER ACTION	(10) MODIFIER AMOUNT	(11) CAT
01.01A	52.43	BMI	BMIANE	Y	Increase By	25%	M+
		BMI	BMIANT	Y	Increase By	25%	
	(6)	ROLE	ANE	Y	Replace Base	104.34	
		ROLE	ANEST	Y	Replace Base	18.39	
		VANE	L30AN		Increase By	108.34	
		VANE	L30AT		Increase By	108.34	
		ANU	ANU				
		(7)	1		For Each Call Pay Base At	100%	
			2-150		For Each Call Increase By	18.39	
		UGA	UGA	Y	Replace Base	134.85	
		SURC	EV	Y	Increase By	48.70	
		SURC	NTAM	Y	Increase By	116.83	
		SURC	NTPM	Y	Increase By	116.83	
		SURC	WK	Y	Increase By	48.70	
		LMTS	L44ANE	Y	Increase Base By	108.34	
		LVP	LVP75	Y	Reduce Base To	75%	

7.5 Health Service Codes that Require Supporting Text/Documentation

03.04Q	08.19K
03.05JG	13.99J
03.05JE	13.99K
03.05JF	13.99KA
08.19AA	13.99KB
08.19BB	39.99A
08.19CC	51.49C
08.19D	52.49A
08.19F	93.03B
08.19H	98.12P
08.19J	98.6G

APPENDICES

Appendix A – Contact Information and Resources

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

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

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

A.1 Additional Alberta Health Contact Information

Mailing address/Fax Number

Correspondence can be mailed to:

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

Fax: 780-422-3552

Telephone/Contact

Check an Alberta patient's PHN and/or its status for a specific date.	Phone: **780-422-6257** Toll-free: **1-888-422-6257** (24-hour access - automated service, no access to staff.) **Do not give out this number** to the general public.
Information about: • H-Link submitter accreditation. • Application support.	Phone: **780-644-7643** (8:15 a.m. – 4:30 p.m.) **Do not give out this number** to the public.

Request a replacement Statement of Assessment. • You will need to provide your Business Arrangement number and the statement date. • Ensure 15 business days have elapsed since the statement date before calling.	Phone: **780-415-8731** (24-hour access) The public also uses this number to request other information.
General inquiries about AHCIP coverage and benefits.	Phone: **780-427-1432** (8:15 a.m. – 4:30 p.m.) The public also uses this number to request information.

A.2 Alberta Health Resources

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

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

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

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

A.3 Obtaining Health Legislation and Regulations

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

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

Appendix B – Billing Tips

B.1 Alberta Claims

Visits and consultations:

- HSC for these services are found under the "Clinical Evaluation and Examination" section in the Procedure List and Price List in the SOMB.
- Governing Rule 4.3 in the Schedule determines whether the consultation was comprehensive, limited or time-based.
- The amount payable for the service varies according to the physician's skill. The Price List contains these different rates.

Special callbacks:

- Claims for special callbacks to hospital in-patient, outpatient and emergency departments must meet the criteria listed in general rule. Please refer to Governing Rule(s) 15.3 – 15.8 in the Schedule for additional information and clarity. https://www.alberta.ca/fees-health-professionals.aspx.
- Benefits may **not** be claimed for subsequent patients seen during the same callback or in association with another service during the same encounter.
- For special callbacks to hospital emergency/outpatient department, auxiliary hospital, or nursing home, see Governing Rule 5.2 in the Schedule and the notes following HSC 03.03MD.
- For special callbacks to hospital outpatient departments, auxiliary hospitals and nursing homes, benefits may be claimed for second and subsequent patients during the same callback.

Services unscheduled:

- When a hospital service occurs outside the physician's usual working hours (see Governing Rule 15.7 in the Schedule), enter a "services unscheduled" modifier in the Modifier field.
- For time blocks, refer to the modifier definitions.
- Physicians who are working scheduled shifts in a hospital setting or are initiating services (e.g., weekend rounds) **may not** claim for callbacks or the surcharge modifier. **Exception:** physicians on rotation duty who are eligible to claim the rotation duty off-hours benefits as outlined in Governing Rule 5.1.1 in the Schedule.

LEVL:

- This implicit modifier refers to the variation in payment for HSC 03.03D based on the number of consecutive days the physician visited the patient in hospital. The payment level is based on the hospital admission date and the physician's skill code.

Transfer of care:

- When a second physician takes over the care of a patient from another physician in the same facility as set out in Governing Rule 4.10 in the Schedule, modifier TOC must be entered on the second physician's claim. The patient's original admission date must also be entered.

Lesser value procedure:

- Modifier type **LVP** is used to code multiple procedures that are performed together. Procedures submitted with an LVP modifier are paid at 100%, 75% or 50%, depending on the applicable general rule. The Price List shows which HSC are eligible for modifier codes LVP75 and LVP50.

  Modifier **ADD** means a procedure is paid at 100% of the base rate or at the rate specified in the Price List when it is performed in conjunction with certain other procedures.

Variable anaesthetic:

- **VANE** modifiers are implicit codes used to indicate specific rate adjustments for role ANE, ANEST and 2ANES.

  Example: an additional benefit may be claimed per case for anaesthetic services provided to patients under 10 years old. The claims processing system will automatically add the implicit variable anaesthetic modifier AGEL10 to increase payment of an eligible claim.

  The additional benefit is payable once per encounter, regardless of the length of time for the anaesthetic or the number of services provided during the encounter.

Time-based services:

- Physicians claiming time-based units for anaesthetic or surgical assists must code the entire elapsed time against the primary procedure, even if multiple procedures are performed.

  Example, if procedures A and B take a combined total of two hours, claim two hours against procedure A.

- For anaesthetic time units (ANU), each 5-minute time block is considered one call. For surgical assist units (SAU), the first hour is one call and any subsequent 15-minute time block is another.

Tray service:

- Governing Rule 14 in the Schedule lists the HSC that are eligible for payment of a tray service.
- Tray services are automatically calculated by the claim processing system and paid according to the number of services performed. If additional trays are required for multiple services, the explicit modifier NBTR must be entered on the claim.
- Tray services are not payable for services provided in a hospital, advanced ambulatory care centre or urgent care centre.

  If trays are provided by a hospital for an outside surgical suite **at no cost**, only the fee for the procedure should be entered, and Y should be entered in the Claimed Amount Indicator field.
  - Claims submitted for services performed in a non-hospital surgical suite contracted by Alberta Health Services will not pay for tray services. Please see Governing Rule 14 for more information.

Appendix C – Provincial/Territorial Health Plan Contact Information

Newfoundland and Labrador

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

Prince Edward Island

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

Nova Scotia

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

New Brunswick

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

Québec

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

Ontario

Ontario Health Insurance Plan (OHIP) Service Ontario, INFOline: 1-866-532-3161 TTY: 1-800-387-5559
Website: Your health | ontario.ca
Time limit: 6 months

Manitoba

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

Saskatchewan

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

British Columbia

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

Yukon Territory

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

Northwest Territories

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

Nunavut

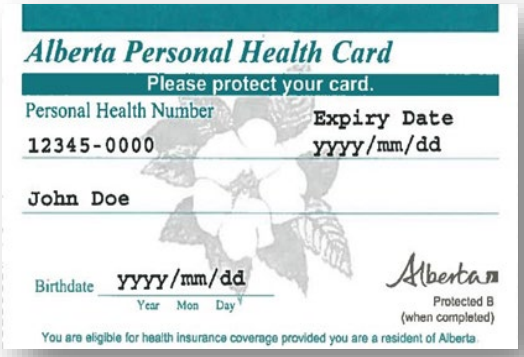
Nunavut Health Care Plan
Telephone: 867-645-8001
Toll free (throughout Canada): 1-800-661-0833
E-mail: nhip@gov.nu.ca
Website: Contact us | Government of Nunavut
Time limit: 6 months

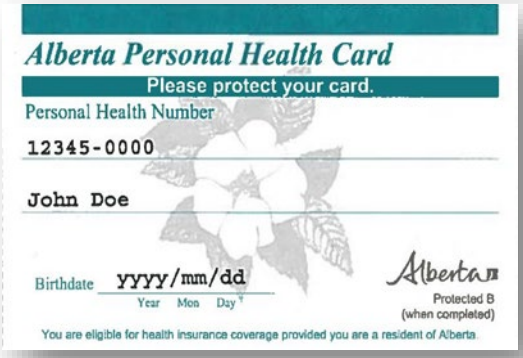
Appendix D – Valid Provincial/Territorial Health Cards

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

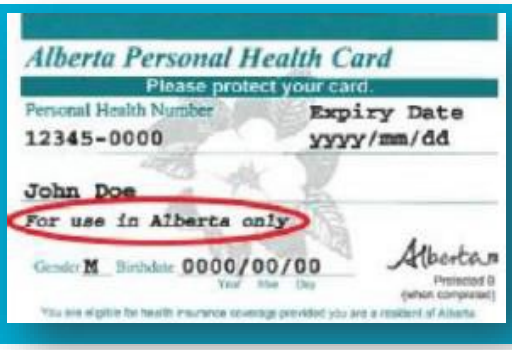
ALBERTA

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



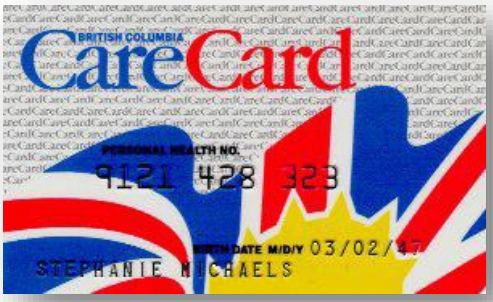


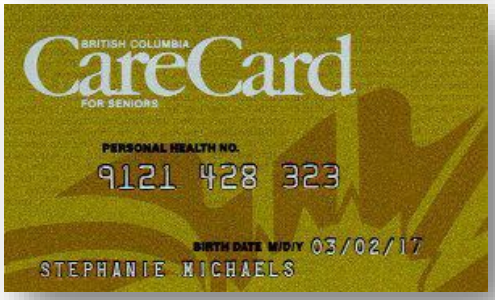
Alberta issues a health card to persons eligible for benefits under Alberta's Ukrainian Evacuee Temporary Health Benefits Program. This card is valid only in the province of Alberta and cannot be used for Reciprocal Billing.



BRITISH COLUMBIA

Recovery Code – BC



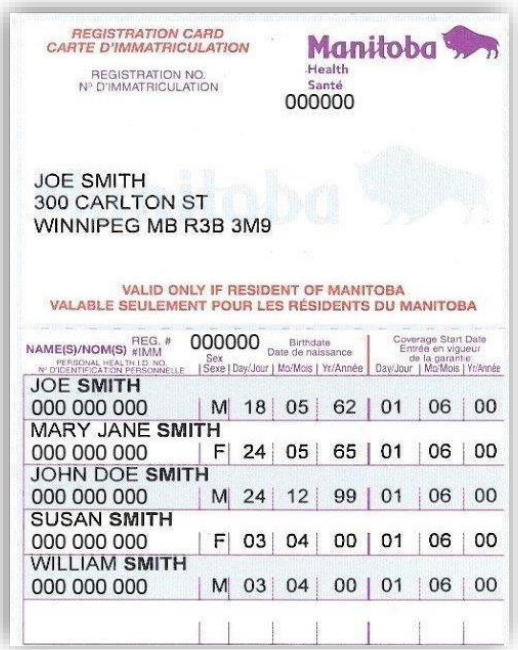


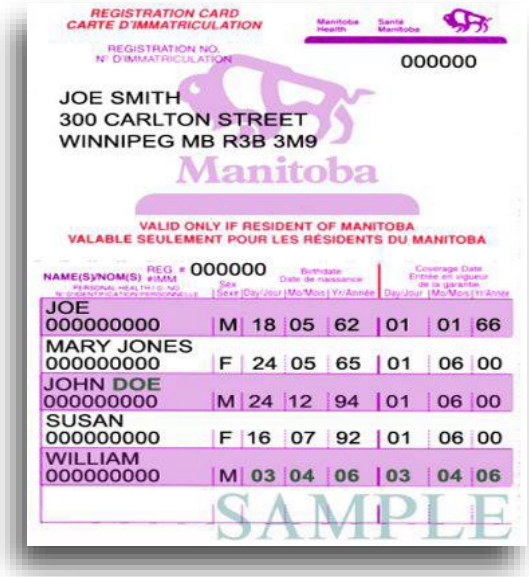
- The regular card is on a white background with the word "CareCard" filling the background in grey.
- The words "British Columbia Care" are blue and "Card" is red. The flag is red, blue, white, and yellow. Plan member information is in black.
- A gold CareCard is issued to seniors a few weeks before they reach age 65. It is gold with the words "British Columbia CareCard FOR SENIORS" in white. Plan information is also in white.
- Since the beginning of February 15, 2013, the B.C. provincial government introduced the BC Services Card, which has been phased in over the five-year period. The new card replaces the CareCard. It is secure government-issued identification that British Columbians can use to prove their identity and access provincially funded health services.
- BC Service Card may act as both a Healthcare Card (access to publicly funded health services through the Medical Service Plan (MSP)) and/or a Drivers ID/Photo ID.
- Some BC residents may have a non-photo BC Services card.
  These residents include children and youth under 19, adults with temporary immigration status, adults 75 and older.
  Additional Information can be found on the BC website: https://www2.gov.bc.ca/gov/content/governments/government-id/bc-services-card.

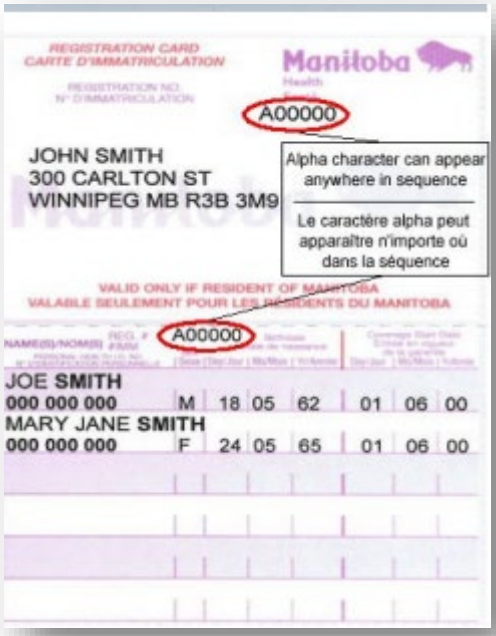
MANITOBA

Recovery Code – MB

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



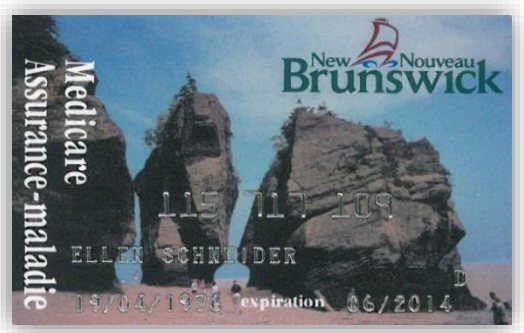


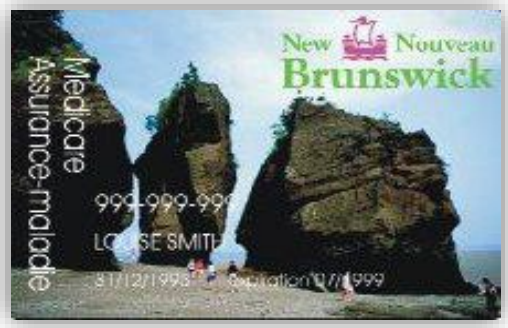


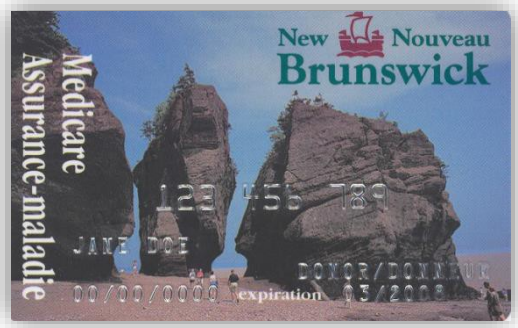
NEW BRUNSWICK

Recovery Code – NB

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



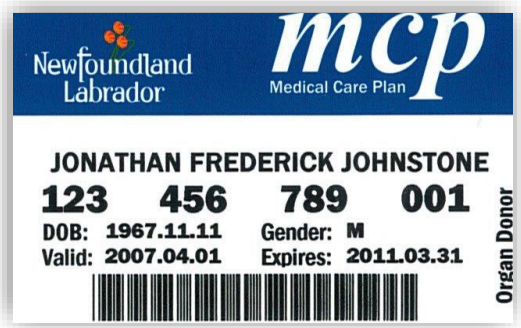




NEW FOUNDLAND AND LABRADOR

Recovery Code – NL

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



NORTHWEST TERRITORIES

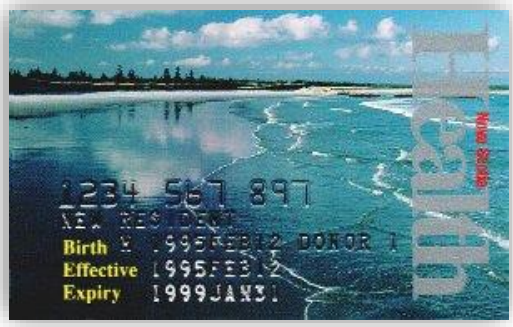
Recovery Code – NT

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

NOVA SCOTIA

Recovery Code – NS

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



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

NUNAVUT

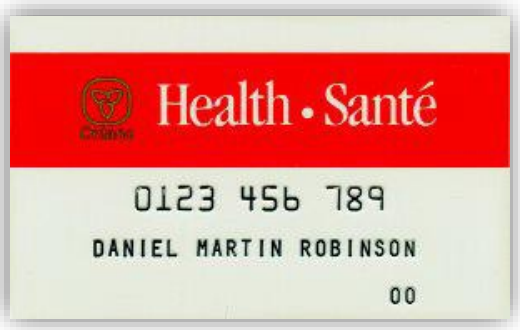
Recovery Code – NU

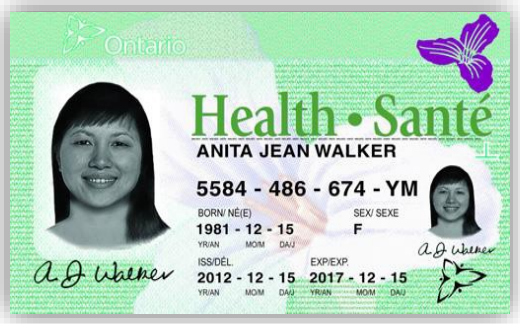
- The Nunavut health card is made of pale grey plastic.
- It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages.
- In the upper portion of the card the word NUNAVUT appears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

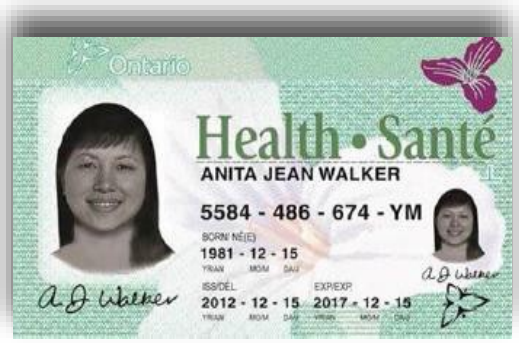
ONTARIO

Recovery Code – ON

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



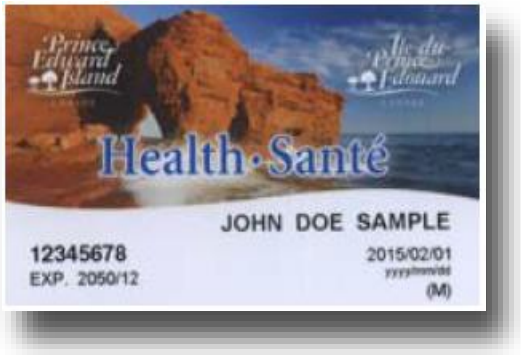




PRINCE EDWARD ISLAND

Recovery Code – PE

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



QUEBEC

Recovery Code – QC

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

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

SASKATCHEWAN

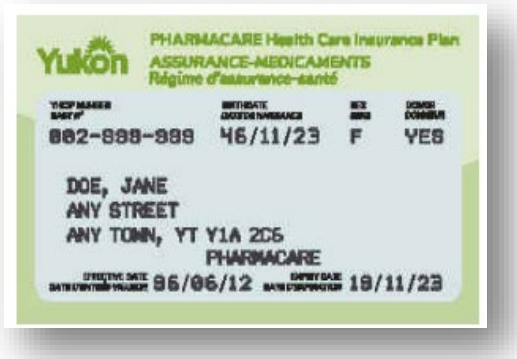
Recovery Code – SK

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

YUKON

Recovery Code – YT

- The newer style Pharmacare card is a light green with a medium green logo and text. The label affixed to both cards is the same style and colour.
- A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card.
- The green health care card entitles holders to all seniors' benefits, hospital, and 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.



Appendix E – Glossary

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

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

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

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

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

Alternate relationship plan (ARP)
A mechanism to compensate physicians providing insured services in a manner other than traditional fee-for- service. The current ARP models are Contractual, Capitation and Sessional.

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

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

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

Basic health benefits
Services deemed medically required according to the *Canada Health Act* and provided by 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 physicians with other important information.

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

Business arrangement number

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

By assessment
A specific procedure with a HSC but no base rate listed in the Schedule of Medical Benefits. Physicians 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 physician benefits schedules, including Alberta's Schedule of Medical Benefits.

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

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

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

Community mental health clinic
A facility operated by Alberta Health Services for the provision of community-based mental health services.

Confidential claims
Claims for services that the patient does not want to appear on their Statement of Benefits Paid.

Contract holder

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

Default skill
The primary skill used by physicians to perform all or most services. Physicians 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.

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

Diagnostic code

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

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

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

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

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

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

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

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

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

Fee modifier code
A code used on a claim in conjunction with a HSC to increase or decrease the base payment amount for a health service. Modifiers are explicit or implicit. Explicit modifiers are entered by the physician. 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 neonatal intensive care, surgical and emergency departments.

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

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

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

Locum period
The period of time during which a locum tenens physician provides services in the absence of another physician.

Locum tenens
A physician providing services for another physician who is temporarily away from work. Locums must register with Alberta Health and have a locum tenens business arrangement.

Medical reciprocal program
The process by which Canadian physicians can obtain payment from their provincial health plans for medically required services provided to eligible residents of other participating provinces and territories. Quebec does not participate in the medical reciprocal program.

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 physician or to an opted-out Alberta resident are to be paid by the resident.

Out-of-Country Health Services Committee
A prior approval committee that considers applications received for Alberta residents, from their physician/dentist for funding of insured medical, oral surgical and/or hospital services that are not available in Canada.

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 appendectomy 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 physician would be paid at zero.

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

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

Practitioner
A licensed individual who provides health services.

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

Provider
(See Health service provider.)

Recovery code
A code on a medical reciprocal claim that identifies which provincial/territorial health care plan will be invoiced to recover the cost of services provided in Alberta to a resident from another province/territory.

Registered physician enrolled
A physician who is registered as a medical practitioner or an osteopath under the *Medical Profession Act* is deemed to be enrolled as a physician in the AHCIP under section 8 of the *Alberta Health Care Insurance Act*, unless they formally elect to opt out of the public health system.

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

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

Resident of Alberta
A person who is legally entitled to be or to remain in Canada and makes his/her permanent home in Alberta; does not include tourists, transients or visitors to Alberta. A resident is not entitled to coverage under the AHCIP if he/she is a

member of the Canadian Armed Forces, a person serving a term of imprisonment in a federal correctional facility or has not completed the waiting period prescribed by the regulations.

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

Schedule of Medical Benefits
The listing of insured physician services. It contains the General Rules, Procedure List, Price List, Explanatory Codes and Fee Modifier Definitions sections, as well as anaesthetic rates applicable to dental, podiatry and podiatric surgery services.

Service provider
(See Health service provider.)

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

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

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

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

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

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

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

Submitter
(See Accredited submitter.)

ULI
Unique Lifetime Identifier: created for all individuals registered with Alberta Health by an Alberta Registry, a hospital or by Alberta Health. Anyone can receive a ULI, however there is no eligibility under the AHCIP tied to the ULI number.

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

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