

Alberta Health

Physician's Resource Guide

November 2017

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

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.

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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:

- 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. A current copy of the Schedule of Medical Benefits is available at the Alberta Health website at <http://www.health.alberta.ca/professionals/SOMB.html>.

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 ([See Section 2.1 – Alberta Residents](#)), and
- residents of other Canadian provinces/territories (except Quebec residents) under the medical reciprocal program. ([See Section 5.0 - Out-of-Province Patient Claims/Medical Reciprocal Billing.](#))

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.

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) are not to be submitted to the AHCIP. They should be submitted directly to the WCB. ([See Section 4.7 – 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 Information form - AHC0912. 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.

1.4 Practitioner Information Form (AHC0912) – Instructions for Completing

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



Note: If you are a **salaried or contract physician** who does not submit claims to the AHCIP but refers patients to physicians who do bill the AHCIP, you should still register as a referring physician. Complete sections A, B, D and H of the Practitioner Information form, and be sure to attach all required documentation. No other forms are required.

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

Section C: **Organization information** – Complete this section if you want to set up a business arrangement in a name other than your own, such as a professional corporation or clinic. Payments will be directed to the corporation/clinic. If you are a professional corporation, you will need to attach a copy of “Form F”, provided to you by the College of Physicians & Surgeons of Alberta.

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

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

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



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

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

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

The Practitioner Information Form is available online at:

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

Section 1.0 – AHCIP Basics for the Physician

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

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

Degree granted	Graduation date <small>Year Month Day</small>	Institution name	Province/ State	Country

College or association registered with _____

Date registered Year Month Day Licence number _____

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

_____ Year Month Day

_____ Year Month Day

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

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

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

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

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

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

Indicate which skill will be used on most claims _____

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

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

Effective Year Month Day I will be joining BA Number _____

Indicate which skill will be used on most claims _____

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

Practitioner signature _____ Phone number _____

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

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

Section G - Facility and functional centre information

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

New facility number effective

Year	Month	Day

Facility name

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

City/Town

Province

Postal code

Indicate the functional centre(s) in your facility

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Examination room
(Practitioner's office) | <input type="checkbox"/> Clinical lab* | <input type="checkbox"/> Non-hospital surgical suite* | <input type="checkbox"/> Electrodiagnosis* |
| <input type="checkbox"/> Diagnostic imaging* | <input type="checkbox"/> Other diagnostic lab* | <input type="checkbox"/> Radiology oncology* | |

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

Practitioner's signature _____ Date _____

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

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

Glossary of Terms

- Accredited Submitter:** An organization or individual accredited by Alberta Health to transmit electronic claims and retrieve results of transactions for practitioners.
- Alternate Relationship Plan:** A mechanism to remunerate practitioners in a manner other than the traditional fee-for-service method.
- Business Arrangement:** An agreement with Alberta Health to establish the arrangement for the payment of health services provided. All practitioners registered with Alberta Health must have or be part of a business arrangement in order to claim for services.
- Contract Holder:** A person, organization, or professional corporation entering into a business arrangement with Alberta Health.
- Registration Understanding and Acknowledgement:** A document provided by the College of Physicians and Surgeons which contains details on the terms and conditions of practice for the physician.
- Statement of Account:** A statement outlining the amount Alberta Health has released for payment based upon the claims assessed. Production of the statement is timed with the weekly payment cycle.
- Statement of Assessment:** A statement detailing the assessment result of each claim submitted. Claims reduced, refused, or paid at zero will have an explanatory code.

1.6 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.

<p>Facility Registration: AHC0910A</p>	<p>To set up a new facility, or if you are moving to a new site that is not yet registered with Alberta Health.</p>
<p>Organization Information: AHC0911</p>	<p>To register a professional corporation or clinic.</p>
<p>Business Arrangement Request: AHC0913</p>	<p>To set up a new business arrangement, change information on an existing business arrangement, or end an existing business arrangement.</p>
<p>Business Arrangement/Service Provider Relationship: AHC0914</p>	<p>To be added to an existing business arrangement, or to change information about your relationship with an existing business arrangement.</p>
<p>Direct Deposit Request: AHC1143</p>	<p>To change the direct deposit banking information for your claim payments.</p>
<p>H-Link Application for Submitter Role: AHC2210</p>	<p>To apply to be your own submitter.</p>
<p>Submitter/Client Relationship for Electronic Claim Submission: AHC2096</p>	<p>To authorize an accredited submitter to submit claims on your behalf, or to change from one submitter to another.</p>




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

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

Following are samples of the various forms a 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 print them from our website at:

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

1.6.1 Facility Registration (AHC0910A) – Sample



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

Facility Registration Delivery Site Registry

For AH office use only

DSR#

DID#

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

Section A - Add/Change/End a Facility

<input type="checkbox"/> Add a new facility Effective Date Year Month Day	<input type="checkbox"/> Change to an existing facility Effective Date Year Month Day Facility Number	<input type="checkbox"/> End an existing facility Effective Date Year Month Day Facility Number
---	--	--

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

Delivery site type: Practitioner office

Section B - Facility Identification

Facility common name

Organization name (Legal name registered with Alberta Corporate Registry)

Practitioner's name (only one required) Practitioner ID

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

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

City/Town/Municipality Province Country Postal Code

Yes change my business mailing address to that above.

Facility (Delivery Site) communications

Business phone number Business fax number Business email

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

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

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

Name and position/title


Date (yyyy-mm-dd) Signature

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

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

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

1.6.3 Business Arrangement Request (AHC0913) – Sample



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

Business Arrangement (BA) Request

For AHW office use only

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

Section A - Identification, type and date of change

The business arrangement contract holder is:

Practitioner identifier

or

PC or clinic ULI

Name

Effective Year Month Day

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

Business arrangement number to change or end

Section B - Business arrangement information

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

Direct deposit to Chequing – attach a void cheque

or

Savings – attach documentation from financial institution indicating bank, branch transit, and account number

Make payment to Me or My PC/clinic or name

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

Identifier

Identifier

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

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

Suppress Statement of Assessment production Yes No

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

Indicate the skill that will be used on most claims

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


Practitioner's signature	Phone number
BA contract holder signature/ARP authorized representative signature	Phone number
BA contract holder name and position/title/ARP authorized representative name	Date

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

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

AHC0913 (2013/03)

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



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

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

For AHW office use only

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

Section A - Type and Date of Change

	Business Arrangement number	Effective date
<input type="checkbox"/> Add me to the Business Arrangement (BA)	_ _ - _ _	Year: _ _ Month: _ Day: _
<input type="checkbox"/> Change my start date with this BA	_ _ - _ _	Year: _ _ Month: _ Day: _
<input type="checkbox"/> Change my BA default skill to _____	_ _ - _ _	Year: _ _ Month: _ Day: _
<input type="checkbox"/> End my relationship with the BA	_ _ - _ _	Year: _ _ Month: _ Day: _

BA Contract Holder Name _____

Practitioner Name _____ Practitioner ID |_|_| - |_|_|

Indicate the skill that will be used on most claims _____

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

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



Practitioner's signature	Phone number
BA contract holder signature/ARP authorized representative signature	Phone number
BA contract holder name and position/title/ARP authorized representative name	Date

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

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

AHC0914 (2013/03)

1.6.5 Direct Deposit Request (AHC1143) – Sample

		Direct Deposit Request Alberta Health Care Insurance Plan	
The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the Health Information Act and section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of enrolling you for programs or benefits funded by Alberta Health. The confidentiality of this information and your privacy are protected by the provisions of the Health Information Act and the Alberta Health Care Insurance Act. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative toll-free within Alberta at 310-000 then 780-422-1522 or by mail at Alberta Health, Claims Management Unit, PO Box 1360 Stn Main, Edmonton AB, T5J 2N3.			For AH Office Use Only
Comments (as applicable):			
NOTE: If you change your financial institution or close your direct deposit account, please update your account information as soon as possible.			
Practitioner Information (Complete the identifier to be used for this banking information)			
Practitioner Identifier	OR	Professional Corporation (PC) or Clinic ULI:	
Practitioner Last Name:	Legal First Name:	Middle Name:	
Professional Corporation or Clinic Name:			
Banking information to be applied to:	BA Number: + -	Effective Date (yyyy-mm-dd):	
For Direct Deposit Attached is: <input type="checkbox"/> a void cheque <input type="checkbox"/> documentation from a financial institution indicating bank, branch transit, and account number.			
Bank Information (To be completed by the financial institution if not attaching a void cheque or bank documentation)			
Name of Bank, Credit Union, Etc.			
Bank Address			City/Town
Bank Transit/Branch Number	Bank Number	Account Number	
Bank Stamp	If you have a cheque for the account, send one with "VOID" written on the front. OR If you do not have a cheque for the account, take this form to where the account is located. Have a bank officer sign and stamp to verify the above banking information or provide the information on their own form.		
	Telephone Number	Date	Financial Institution Officer's Signature
Practitioner Authorization (This section must be completed)			
I, the practitioner, authorize Alberta Health to deposit payments into the account shown above. I understand I must notify Alberta Health immediately if the account changes or is to be closed.			
Contact Number:	Name:	Date (yyyy-mm-dd):	Practitioner Signature:
BA Contract Holder Authorization (This section must be completed)			
I, the Business Arrangement Contract Holder, verify that the information provided in this form is correct and that I am able to authorize the changes identified above regarding banking information for the business arrangements shown above. I understand I must notify Alberta Health immediately if the account changes or is to be closed.			
Contact Number:	Name:	Date (yyyy-mm-dd):	BA Contract holder/ARP Authorized Representative Signature:
Send completed forms to the Professional and Facility Management Unit via fax to 780-422-3552 or via email to Health.PracForms@gov.ab.ca			
Refer to the instructions for help completing this form. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.			
AHC1143 (2017/08)			Page 1 of 1

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

Alberta Government

H-Link Application for Submitter Role

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

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

For information on completing this form, see page 2.

Section A - Submitter Role		
Please check one of the following:		Date (yyyy-mm-dd)
<input type="checkbox"/> Amend (<i>underline amendments</i>) <input type="checkbox"/> Create <input type="checkbox"/> Delete		
Name (practitioner or organization)		Practitioner ID (if already assigned)
Business phone number	Business fax number	Business email
Mailing address (include city, province and postal code)		
Physical address (include city, province and postal code)		
Section B - Technical Software Contact Information		
Name		
Business phone number	Business fax number	Business email
Section C - Submitter Agreement		
I hereby authorize the creation, amendment or deletion of a Submitter Role.		
I confirm that the above named Submitter is an affiliate of the Custodian (practitioner or organization named above) under the <i>Health Information Act</i> .		
I confirm that I understand my obligations associated with the management of health information, including any actions taken by the Submitter as my affiliate, as outlined in the <i>Health Information Act</i> .		
I confirm that I have read and will comply with the Alberta Health Electronic Claims Specification (H-Link) Manual. I understand the manual may be amended from time to time at the sole discretion of Alberta Health.		
Last name	First name	Middle name
Business phone number	Date (yyyy-mm-dd)	Signature
Section D - Accreditation (Alberta Health)		
Authorized by	Signature	
Submitter prefix code	Date (yyyy-mm-dd)	

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

Mail or fax the completed forms to: Alberta Health
 Attention: H-Link Administrator
 PO Box 1380 Stn Main
 Edmonton, AB T5J 2N3

Fax: 780-422-7248

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Save Form
Print Form

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

Government of Alberta		Submitter/Client Relationship for Electronic Claim Submission	
Alberta Health and Wellness Professional and Facility Management Unit PO Box 1360 Station Main Edmonton AB T5J 2N3		For AHW office use only	
Business Arrangement contract holder			
Name _____		Practitioner identifier (PRAC ID) or BA contract holder ULI _____	
Business address _____		Proposed commencement date _____	
_____		Contact name _____	
_____		Contact phone number _____	
_____		*BA number(s) _____	
<p>*Note: (1) If there is more than one practitioner registered on the BA, only the BA contract holder's signature is required. We do not require a form from each practitioner on the BA. (2) If adding a practitioner to a BA, this form is not required.</p>			
Submitter			
Name _____		Submitter prefix code _____	
ULI number _____		Proposed submission date _____	
Contract holder certification and agreement		Submitter certification and agreement	
I hereby authorize this accredited submitter to submit my claims electronically on my behalf. I further certify that my agreement with the accredited submitter, who is party to this application, conforms fully to the Electronic Claims Submission Specifications Manual and the <i>Alberta Health Care Insurance Act</i> and Regulations and that I am fully responsible for the correctness and security of all information submitted to obtain payment of claims.		I hereby certify that my agreement with the contract holder, who is party to this application, conforms fully to the Electronic Claims Submission Specifications Manual.	
Signature(s) _____		Signature(s) _____	
_____		_____	
Name(s) _____		Name(s) _____	
_____		_____	
Date _____		Date _____	
Return completed forms to the Professional and Facility Management Unit at the address above, or fax to 780-422-3552. If you need assistance completing this form, please refer to your Resource Guide. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.			
Information collected is used to enrol you for programs or benefits funded by Alberta Health and Wellness. It is collected under the authority of sections 20(b) and 27 of the <i>Health Information Act</i> . The confidentiality of this information and your privacy are protected by the provisions of the <i>Health Information Act</i> and the <i>Alberta Health Care Insurance Act</i> . If you have questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address, telephone or fax number provided above.			
AHC2096 (2010/04)			

1.7 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 section E on the Practitioner Information form - AHC0912.

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.



Note: 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.

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

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. (See Section 1.12 - Locum Tenens.) |
| Alternate relationship plan: | A mechanism to compensate physicians in a manner other than the traditional fee-for-service method. (See Section 1.13 - Alternate Relationship Plans.) |

1.7.1 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 forms:

- Organization Information - AHC0911. Attach a copy of “Form F”, provided to you by the College of Physicians & Surgeons of Alberta.
- Business Arrangement Request - AHC0913.
- If applicable, Business Arrangement/Service Provider Relationship - AHC0914. This identifies any other physician(s) who will also be billing through the business arrangement number (e.g., a clinic).

1.7.2 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 section E on the Practitioner Information form - AHC0912.
- As applicable, physicians completing the Business Arrangement Request - AHC0913 and Business Arrangement (BA)/Service Provider (SP) Relationship -AHC0914 forms also indicate their default skill.

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

1.7.3 The business arrangement and direct deposit

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

- When a new physician is setting up a new business arrangement, they provide their direct deposit details in section E on the Practitioner Information form - AHC0912.
- When a registered physician is setting up a new business arrangement, they provide their direct deposit information for that new business arrangement by completing a Business Arrangement Request form - AHC0913.
- When a new physician is joining an existing business arrangement (section F on the AHC0912 form), the direct deposit provision already established for that business arrangement applies.
- A registered physician who wishes to change their direct deposit information for an existing business arrangement must complete a Direct Deposit Request form - AHC1143.

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



Note: Completed forms and void cheques can be faxed to 780-422-3552; however, the pre-printed bank numbers on the cheque may not be legible when received. Please ensure banking information is legible; otherwise, the processing of your request may be delayed.

1.7.4 The business arrangement and the submitter

Claims are sent to the AHCIP via an accredited submitter using the electronic H-Link method. All business arrangements **must** have an accredited submitter attached to them in order for claims to be submitted for payment. ([See Section 1.12 - 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 Submitter/Client Relationship for Electronic Claim Submission form - AHC2096.
 - If you want to be your own submitter, you will need to complete an H-Link Application for Submitter Role - AHC2210.

More information about obtaining the services of an accredited submitter or becoming your own submitter is available by calling H-Link Application Support in Edmonton at 780-644-7643. To call toll-free in Alberta, dial 310-0000 then enter 780-644-7463 when prompted. You can also send an email to health.hlink@gov.ab.ca



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

1.8 Registering Your Facility

If you are setting up a brand new office, clinic or other facility, you must register the facility with Alberta Health. Facility registration identifies the physical location (provider office, diagnostic imaging facility, etc.) where health services are routinely performed, as well as any functional centre(s) within the facility (examination room, etc.).

- Each facility is assigned a facility number. This number is address-linked (i.e., not transferable to another physical location) and remains the same no matter how many 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 College of Physicians & Surgeons of Alberta (CPSA) indicating that the facility is accredited/approved to perform its associated services such as diagnostic imaging, stress testing, and pulmonary function.

1.9 Changing the Location of Your Practice

When you change the physical location of your practice, you will also have to change your facility number. Notify the Provider Relationship and Claims unit at 780-422-1522 or fax the completed Facility Registration/Delivery Site Registry form - AHC0910A to Alberta Health at 780-422-3552.

1.10 Mandatory Address Reporting

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

1.11 Buying an Existing Practice or Clinic

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

Organization Information:
AHC0911

To identify the name of the clinic or professional corporation.

Business Arrangement Request:
AHC0913

To set up a new business arrangement.

Business Arrangement/Service Provider Relationship:
AHC0914

If other 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.

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

1.12 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 Request form - AHC0913.

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

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.

Claim field requirements

- 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.



Note: 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.

If using payment option #3 described above, the locum business arrangement will need an accredited submitter. Complete a Submitter/Client Relationship for Electronic Claim Submission form - AHC2096.

1.13 Alternate Relationship Plans

Physicians may choose to participate in an Alternate Relationship Plan (ARP). ARPs compensate physicians providing insured services in a manner other than the traditional fee-for-service method. Currently, there are three different clinical ARP models: Contractual, Capitation and Sessional.

Any clinical ARP proposal to be considered for alternate funding must be submitted to the ARP Program Management Office at:

ARP Program Management Office
12230-106 Avenue NW
Edmonton AB T5N 3Z1

Phone: 780-453-3130

Toll-free: 1-866-953-3130

Fax: 780-453-3599

Email: inquiries@arppmo.org

More information about ARPs is available at www.health.alberta.ca/professionals/alternative-relationship-plans.html.

1.14 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*.

1.14.1 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 Schedule of Medical Benefits.

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 on the Alberta Health website at www.health.alberta.ca/about/health-legislation.html. A printed version is available from the Alberta Queen's Printer at www.qp.alberta.ca.

1.14.2 Opted-out physician

By opting out of the AHCIP, a physician agrees that, commencing with the opt-out effective date, they will not participate in the publicly funded health system. This means the total cost of health care services they provide is the responsibility of the patient. A decision to opt out of the AHCIP applies to the physician's personal practice and all business arrangements to which the physician is attached.

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 practises.
3. Post a notice of the proposed opting out in a part of the physician's office where it can be viewed by all patients.

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.



Note: 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 the emergency service. In this situation, the opted-out physician cannot charge a patient over and above the amount listed for that service in the Schedule of Medical Benefits.

1.14.3 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 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

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

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

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

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



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

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

Members of the Canadian Armed Forces and inmates in federal penitentiaries are not covered under the AHCIP.

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

Physicians and office staff can also verify a patient's eligibility using 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 on Alberta Netcare see www.albertanetcare.ca.

2.2 Patients who are Eligible

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

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



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

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

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

2.3 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.

To use the IVR system:

1. Phone 780-422-6257 in Edmonton, or from outside Edmonton call toll-free 1-888-422-6257.
2. After the introductory message, you have 10 seconds to enter the patient's nine-digit PHN and press the # key.

3. At the prompt, enter the date of service for which you are checking the PHN.
 - For today's date, press #.
 - For a date prior to today's date, enter as YYYYMMDD, and then press #.
4. The IVR system will advise you:
 - If the PHN is eligible (i.e., in effect) on the date of service specified.
 - If the PHN is not eligible on the date of service specified.
 - If the PHN is invalid (i.e., not structurally correct).
5. After the IVR system has processed your first inquiry, it will prompt you to press # if you wish to check another patient's PHN. You can check as many PHNs as you need to during the same phone call.



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

2.4 Patients who are not Eligible

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

- Those who have active health coverage in another province. (Persons who have moved to Alberta recently and are still covered under the health plan of another province/territory or are just working in Alberta temporarily.)
- Those who have chosen to formally opt out of the AHCIP.
- Those who have not yet registered with Alberta Health.
- Those who present a health care card that is not active (confirmed by IVR).
- Temporary residents such as foreign workers, students and their dependents' who present an Alberta health care card with a past expiry date, who have not applied for a 90 day extension.
- Canadian Forces personnel and federal penitentiary inmates. These individuals are covered by the federal government and their health cards are different. Services provided to patients in this category should be billed directly to the federal government or other secondary insurer, as applicable.



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

2.5 Patients without an Alberta Personal Health Card

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

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

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



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

2.6 Patients who Opt Out

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

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

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

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

2.7 Options for Patients who do not have Active AHCIP Coverage

- If the patient produces a health insurance card from another province/territory where they claim to have coverage, and the card appears to be valid, submit a medical reciprocal claim for insured services to Alberta Health. ([See Section 5.0 – Out-of-Province Patient Claims/Medical Reciprocal Billing.](#))
You may want to confirm eligibility with the province of origin to ensure payment.
- When patients from Quebec present a health card from Régie de l'assurance maladie du Québec, **complete a Quebec Claim for Physician/Practitioner Services form** ([See Appendix A.3 – Obtaining Alberta Health Resource Material](#)).
- Bill the patient directly and, if applicable, provide the patient with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 to submit to their provincial/territorial health plan ([See Appendix A.3 – Obtaining Alberta Health Resource Material](#)).



Note: 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.

- In extenuating circumstances, you may submit a claim under the good faith policy ([See Section 4.1 - Alberta's Good Faith Policy](#)) if your patient indicates they are not yet registered with the AHCIP but:
 - confirm they have lived in Alberta as a permanent resident for more than three months,
 - are legally entitled to be in Canada (not a tourist, transient or visitor),
 - have identification including identity with their Alberta address, **and**
 - **do not have coverage from their province of origin.**



Note: The good faith policy **does not apply** if the patient has active coverage in another province/territory.

2.8 Patient PHN Problems

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

- Confirm that the PHN on your claim is correct (check for a clerical error). If applicable, submit a new claim with the correct PHN.
- Contact the patient to confirm the status of their health coverage. If you obtain a correct PHN, submit a new claim.
- If you cannot obtain a correct PHN, call our Registration Research unit ([See Section 2.5 - Patients without an Alberta Personal Health Card.](#))
- Complete a Request for Personal Health Numbers form - AHC0406 and fax it to 780-415-1704. We will return the form to you with the research results. This form is not available online; to order a supply call our Registration Research unit.

2.9 Safeguarding Personal Health Cards and Numbers

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

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

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

3.0 Claim Submission

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

Particularly when using a new billing program, ensure the software vendor provides you with the support necessary to understand the processes for producing new and resubmitted claim transactions. This includes knowing how to send person data, supporting text, and supporting text cross-reference segments in cases when this information needs to be attached to base claim segments ([See Section 3.4 - Claim Segments.](#))

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



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

3.1 Claim Basics

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

WHO was involved:

Enter:

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

WHERE it occurred:	Enter the facility number. <ul style="list-style-type: none">• 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. <ul style="list-style-type: none">• If applicable, add the modifier for the time of day.• For time-based services, enter the number of calls required to determine the units of time involved.
WHY the procedure was done:	From the Alberta Health Diagnostic Code Supplement (ICD9), enter the code(s) for the disease, condition or purpose related to the medical service you are claiming.

3.2 Claim Processing Timelines

Physicians have 180 days from the date the health service was provided to submit a claim.

If a claim is being resubmitted, it must be received within 180 days from the date of the last Statement of Assessment on which the claim appeared. A resubmitted claim is not payable if it is resubmitted more than 180 days after the last transaction for that claim. ([See Section 4.4 - Outdated Claims.](#))

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

Exceptions to this payment schedule are:

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

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



Note: The date on which you send your claims to your accredited submitter **is not necessarily** the date on which your submitter sends those claims to Alberta Health.

3.3 Action Codes

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

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

Action code

A (add):

When to use

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 6.5 Result codes.)

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

C (change):

To change the information on a claim that appeared on the Statement of Assessment with result code APLY (applied) ([See Section 6.5 - 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

To correct these details, you must delete the incorrect claims (see action code **D**) and submit new, correct claims (see action code **A**).

- R (reassess):** To resubmit a previously processed claim that was reduced in payment or paid at zero and you wish to have it reassessed with additional supporting information you are now providing.
- Use the same claim number from your Statement of Assessment.
 - Include a supporting text segment with the additional information you wish to have considered. It will be added to any other earlier text on the claim. (Any supporting text cross-reference segment will be automatically connected to the referenced claims.)
 - You do not need a base claim segment, as you are not changing any of the data. **You cannot change any of the data fields with action code R.**

- D (delete):** To delete a claim that was previously paid in full, reduced or paid at zero.
- Use the same claim number from the Statement of Assessment.
 - You do not need a base claim segment or person data segment.
 - You must **delete** the original claim if you want to change any of these details:
 - patient's personal health number
 - physician's PRAC ID
 - business arrangement number
 - locum business arrangement numberThen submit a new claim (action code A) with the correct information and a new claim number.
 - Pay-to-patient claims **cannot** be deleted.

3.4 Claim Segments

Each claim is made up of four basic segments:

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

Each claim segment is used for a different purpose, as described in sections 3.4.1 through 3.4.4. Carefully completing the data fields within the segments helps ensure claim payments are prompt and correct.



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

3.4.1 In-province provider base claim segment – CIB1

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

- Claim Type:** Enter **RGLR** for all action code **A** (add) or **C** (change) claims.
- Leave this field blank for action code **R** (reassess) and **D** (delete) claims.
- PRAC ID:** Enter the practitioner identifier number (PRAC ID) of the physician who provided the service.
- Do not enter a professional corporation identifier number in this field or the claim will be refused.
 - It is **not** appropriate to claim your services under another 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 of 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 College of Physicians & Surgeons of Alberta.
- 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 3.4.2 - 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: Enter the appropriate code from the Procedure List in the Schedule of Medical Benefits.

- Procedures claimed under section 99.09 (Procedures not elsewhere classified) require supporting text/documentation. ([See Section 3.7 - Submitting Claims for Unlisted Procedures.](#))
- It is **not** appropriate to submit a claim using a code from the 99.09 section when a specific health service code for the service provided is listed elsewhere in the Procedure List.

- When an unlisted service is provided, it is **not** appropriate to submit a claim using an established health service code that is similar to the actual procedure performed.

Service Start Date:

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

- For hospital visits (health service code 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 180 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 Schedule.)
- “Encounter number” and “calls” **do not mean the same thing**. Do not use encounter numbers to denote the number of services (calls) you are claiming for a health service code.

Diagnostic Code:

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

- Enter the primary diagnosis in the first Diagnostic Code field. Two additional fields are available for secondary

diagnoses, if needed. They can be used to denote the overall diagnosis or separate health concerns.

- Claims received with diagnostic codes that are not appropriate for the health service code submitted will be refused.

Calls:

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

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



Note: This **does not apply** to health service codes where a maximum fee is specifically indicated in the Procedure List or Price List. The listed maximum fee will not be exceeded for these services regardless of any explanatory text submitted

Explicit Fee Modifier:

Modifiers are used in conjunction with the health service code to determine the amount payable. ([See Section 3.6 - Modifier Codes.](#))

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

Facility Number:

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

- Leave blank if the service was performed in a location that is not a registered facility. (See Location Code field.)
- 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 1.12 - Locum Tenens for locum option details.](#))

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 health service codes 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 Bulletin Gen 81 for more information.

Out-of-Province Referral Indicator:	<p>This field is required only for Alberta patients who are referred by an out-of-province physician.</p> <ul style="list-style-type: none">• 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:	<p>If the claim is a medical reciprocal claim, enter the out-of-province patient’s home province recovery code in this field.</p>
Chart Number:	<p>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.</p>
Claimed Amount:	<p>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 3.7 - Submitting Claims for Unlisted Procedures.)</p> <ul style="list-style-type: none">• Claimed amount is not required for other health service codes unless you are requesting a lower fee than what is listed in the Schedule.
Claimed Amount Indicator:	<p>Enter Y in this field only if the fee you are claiming is less than the amount normally paid for this service.</p>
Intercept Reason:	<p>This field is currently not used.</p>
Additional Compensation (EMSAF Stat):	<p>If the amount is being claimed for additional compensation, as per G.R. 2.6 in the SOMB</p> <ul style="list-style-type: none">• Enter ‘Y’ in the EMSAF indicator field.• Paid on the rate that the physician is entitled to receive according to the schedule.• Text on the claim must be included with the additional amount being requested.• Supporting documentation must include:<ul style="list-style-type: none">• Letter and Operative Report• Total time spent on the procedure

- Confidential Indicator:** Enter Y if the patient has asked that a service not be reported on their Statement of Benefits Paid. ([See Section 4.3 - Confidential Claims.](#))
- Good Faith Indicator:** Enter Y if submitting under the good faith policy. ([See Section 4.1 - Alberta's Good Faith Policy.](#))
- You must complete a person data segment for the patient.
- Newborn Code:** If the patient is a newborn whose PHN is unknown, enter the applicable code:
- LVBR (live birth)
 - MULT (multiple birth)
 - STBN (stillborn)
 - ADOP (adoption)
- 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 5.0 – Out-of-Province Patient Claims/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.
- 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 health service code 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 Schedule) 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 health service code 03.03D and indicate the date on which this care began. (See health service code 03.03E in the Schedule of Medical Benefits Procedure List.)

3.4.2 Claim person data segment – CPD1

This segment must be completed for:

- A patient (RECP) who does not have a PHN or does not know their PHN (i.e., good faith claim – see [Section 4.1 - Alberta's Good Faith Policy](#)).
- A newborn patient without a PHN. ([See Section 4.2 - Newborn claims – Alberta Residents.](#))
- An out-of-province patient eligible under the medical reciprocal program who has not been assigned an Alberta PHN for processing purposes. ([See Section 5.0 - Out-of-Province Patient Claims/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.

- For good faith claims, the only acceptable province code is AB (Alberta).
- 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.

3.4.3 Claim supporting text segment – CST1

Use this segment only if the claim you are sending requires supporting text. When required, this segment is sent at the same time the base claim segment is submitted. ([See Section 7.5 – Health Service Codes that Require Supporting Text/Documentation.](#))

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

3.4.4 Supporting text cross reference segment – CTX1

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

3.5 Mandatory Claim Fields and Segments

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

If the claim involves

- a first-time claim for a newborn:
- the medical reciprocal program:

then you must complete this field/segment

- ✓ newborn code
- ✓ person data segment (including parent/guardian PHN)
- ✓ 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)

3.6 Modifier Codes

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

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

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

Explicit modifiers:

When applicable, the 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:

- **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.)
- **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.

3.7 Submitting Claims for Unlisted Procedures

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

- Determine if the service is insured under the Alberta Health Care Insurance Plan (AHCIP).
- Review the Schedule to determine if a health service code exists for the service – it may be listed in an unfamiliar section, or it may be a combination of services. If you locate a specific health service code(s) for the service, submit the claim accordingly.
- If you cannot identify an appropriate health service code, submit your claim using the appropriate code (99.09A to 99.09V) from the unlisted procedures section of the Schedule.
- When preparing a claim for 99.09A to 99.09V, determine an equivalent or comparable service listed in the Schedule in terms of time, complexity and intensity. Provide supporting information, such as an operative report or descriptive text. Include equivalencies, the service description, time and the amount claimed.

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



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

4.0 Special Situations

4.1 Alberta's Good Faith Policy

The good faith policy was developed to minimize the risk of Alberta practitioners not being paid for services provided to Alberta residents who the practitioner believes are eligible for coverage under the AHCIP at the time of service but cannot provide proof of coverage.

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

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

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



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

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

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

On your good faith claim:

- Enter Y in the Good Faith Indicator field in the base claim segment. ([See Section 3.4.1 - In-Province Provider Base Claim Segment – CIB1.](#))

- Attach a person data segment and enter the personal information collected from the patient, including their name and permanent Alberta address. ([See Section 3.4.2 - Claim Person Data Segment – CPD1.](#))

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

4.2 Newborn Claims – Alberta Residents

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

Base claim segment:

- ✓ Newborn code – enter the applicable code from the following choices:
 - LVBR (live birth)
 - ADOP (adoption)
 - MULTI (multiple births)
 - STBN (stillborn)

Person Data segment:

- ✓ Person type (RECP – service recipient)
- ✓ Surname
- ✓ First name (if known)
- ✓ Middle name (if known)
- ✓ Birthdate (YYYYMMDD)
- ✓ Gender (M or F)
- ✓ Mother's/Guardian's PHN
- ✓ Address
- Do not use dashes, abbreviations or punctuation, or the claim will be refused. (e.g. 2014 Brookview Crescent Regina SK S3S 4R5)



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

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

4.3 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 3.4.1 - 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



Note: 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.

4.4 Outdated Claims

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

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

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

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

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

To help ensure they receive all payments they are entitled to for services provided, physicians (and their staff) are expected to use sound business practices that support timely claim submission and reconciliation practices.

4.5 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 Schedule of Medical Benefits General Rule 3.1(l)

4.6 Sexually Transmitted Infection Claims

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

1. Not eligible for AHCIP coverage, or
2. A transient, refugee, etc., or
3. Not eligible under the medical reciprocal program, or
4. A resident of Quebec, or
5. 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.

4.7 Workers' Compensation Board (WCB) Claims

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



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

The WCB online remittance is available by logging into myWCB at <https://my.wcb.ab.ca/ess/signin>. For information on how to sign in, or to setup a login, visit <https://www.wcb.ab.ca/resources/for-health-care-and-service-providers/online-services.html>. 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 regarding the WCB visit 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 3.3 – Action Codes](#).



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

Where applicable, adjustments will be made monthly to recover Alberta Health payments for services that are the responsibility of the WCB. These adjustments appear on the Statement of Assessment with Explanatory Code 21 (Workers' Compensation Board Claim).

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

A non-resident of Alberta who is working in Alberta and who is injured at work may claim WCB benefits from either the workers' compensation organization of the province where they were injured

or the province where they reside. You will need to check with your patient regarding the province from which they will be claiming WCB benefits. Once this information is confirmed, your office can submit a claim directly to the appropriate provincial workers' compensation organization.



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

4.8 RCMP Member Claims

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

Alberta RCMP members have been issued Alberta Personal Health Cards and are expected to show their Personal Health Card along with photo identification when visiting a 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 who are residents of the other Canadian provinces and territories (except Quebec) will be eligible for payment under the medical reciprocal program.



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

4.9 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:
 1. Pre-contemplation phase
 2. Contemplation phase
 3. Determination phase
 4. Action phase
 5. Care After Death phase
- Medical Assistance in Dying provided during the pre-contemplation and contemplation phases may be billed using existing Health Service Codes, such as visit, team conference, or consultation codes, through the Schedule of Medical Benefits. The contemplation phase ends when one assessment of eligibility for Medical Assistance in Dying is completed.
- For all services provided during the determination, action and care after death phases, physicians should bill 99.09U equated to the Medical Assistance in Dying rate (\$51.80 per 15 minutes).
- After the contemplation phase, no services related to Medical Assistance in Dying may be billed in addition to the 99.09U claim. Concurrent claims for overlapping time for the same or different patients may not be claimed.
- Physicians are required to provide supporting text and documentation with the submission of claims billed through 99.09U. This text must include a detailed summary of all services provided including start and stop times.
- 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.



Note: 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 www.cpsa.ca/standardspractice/medical-assistance-dying/.

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.

4.10 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 Alberta Health Care Insurance Plan (AHCIP) and to be paid at Alberta rates.



Note: 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 Schedule of Medical Benefits. 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 6.10 - Monitoring and Compliance](#))

4.11 Health Care Services Provided 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's legislation and the reciprocal agreements permit compensation only for insured medical and hospital services, the amounts are paid in accordance with the rules and at the rates established by the province that provides the services. Alberta does not provide a mechanism for payment outside of these agreements.

Under the Final Stage Gender Reassignment Surgery (GRS) Program, funding is available for eligible Albertans diagnosed with Gender Identity Disorder, and who meet established program criteria. The GRS Program provides funding for final stage GRS, such as phalloplasty and vaginoplasty.

Please refer to Medical Bulletin 166A for further information or call the Special Programs Unit at 780-415-8744.

All required documentation related to final stage GRS should be sent to:

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

Fax: 780-415-0963

4.12 Health Care Services Provided Outside Canada

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

1. Partial reimbursement through the AHCIP.

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

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

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

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

The Oochsc considers applications for funding of insured medical, oral surgical and/or hospital services that are not available in Canada and operates at arms-length from Alberta Health.

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

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

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

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

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



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

Funding applications that have been denied by the OCHSC can be appealed to the Out-of-Country Health Services Appeal Panel. 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 OCHSC decision, or it may substitute its decision for the OCHSC decision. In addition to medical experts, the Appeal Panel includes a member of the general public and an ethicist.

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

Appeals can be submitted in writing to:

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

5.0 Out-of-Province Patient Claims/Medical Reciprocal Billing

The provinces and territories, with the exception of Quebec, participate in reciprocal medical agreements. Alberta's legislation and the reciprocal agreements permit reimbursement only for insured medical and hospital services.

5.1 Types of Claims Excluded from Medical Reciprocal Billing

- Claims for Quebec residents cannot be submitted to the AHCIP, as Quebec does not participate in this program.
- Good faith claims cannot be submitted for out-of-province patients.
- Workers' Compensation Board (WCB) claims, including claims for out-of-province patients working in Alberta, must be submitted directly to the WCB.
- Confidential claims should be submitted to the patient's home province health plan for payment or billed to the patient. ([See Section 4.3 - Confidential Claims.](#))

5.2 Excluded Services from Medical Reciprocal Billing

Each province/territory has different health care coverage and rules associated with some services. Therefore, the services listed below have been excluded from the medical reciprocal program. Excluded services must be billed to the patient's home province or territory plan or to the patient directly.

- Cosmetic surgery for alteration of appearance
- Sex-reassignment surgery
- Surgery for reversal of sterilization
- Routine periodic health exams, including any routine eye exams
- 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, employment medical)

- Team conference(s) (Health Service Codes: 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 (Health Service Code 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



Note: Effective June 18, 2015, medical costs associated with providing therapeutic abortion services to out-of-province/territory patients in an Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC) approved public facility should be billed reciprocally according to the Alberta's Schedule of Medical Benefits and rules of application.

For the therapeutic abortion service to be reciprocally billed the out-of-province/territory patient must present a valid health card and the service must be provided in an IHIACC approved public facility.

5.3 Physician Billing

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.



Note: 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.

2. If a valid health insurance card is not presented or if the service is not eligible under the medical reciprocal program, complete an Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. Submit the claim to the patient's home province or territory for payment consideration ([See Appendix A.3 – Obtaining Alberta Health Resource Material](#)).
3. Quebec does not participate in the medical reciprocal program. Please complete a Quebec Claim for Physician/Practitioner Services form found on the Alberta Health website.

4. 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.



Note: 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.

Superseded

5.5 Submitting a Claim

Similar to claims for services provided to Alberta residents, medical reciprocal claims are submitted electronically to the AHCIP and are processed using Alberta's Schedule of Medical Benefits, regulations and assessment rules.

To claim under the medical reciprocal program:

- The service provided must be insured under the AHCIP.
- The service must not appear on the excluded services list. ([See Section 5.2 - Excluded Services from Medical Reciprocal Billing.](#))
- The patient must show you a current health insurance card from their province/territory of residence. ([See Appendix C – 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. 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.

5.6 Out-of-Province Patient Eligibility

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



Note: Quoting a number without presenting a card is not acceptable. **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 5.3](#) 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 C](#). If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office to resolve any beneficiary entitlement concerns.

5.7 Province/Territory Contact Information and Claim Submission Time Limits

Newfoundland and Labrador

Medical Care Plan (MCP)
Toll-Free 1-800-563-1557
Tel: 709-292-4027
E-mail: healthinfo@gov.nl.ca
Website:
<http://www.health.gov.nl.ca/health/departments/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:
<http://www.gov.pe.ca/health/index.php3?number=1018473>
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: www.ramq.gouv.qc.ca/en/contact-us/citizens/Pages/contact-us.aspx
Time limit: 3 months

Manitoba

Registration & Client Services Manitoba Health
General Inquiries Line: 204-786-7101
Toll free in North America: 1-800-392-1207
Email: insuredben@gov.mb.ca
Website: www.manitoba.ca/health/mhsip
Time limit: 6 months

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](mailto:mспенquiries@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

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

Ontario

Ontario Health Insurance Plan (OHIP)
Service Ontario, INFOLine: 1-866-532-3161
TTY: 1-800-387-5559
Website: <https://www.ontario.ca/page/apply-ohip-and-get-health-card>
Time limit: 6 months

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

Yukon Territory

Health Care Insurance Plan
Telephone: 867-667-5209
Toll Free within the Territory: 1-800-661-0408 ext. 5209
E-mail: hss@gov.yk.ca
Website: <http://www.hss.gov.yk.ca/contactus.php>
Time limit: 6 months

Nunavut

Nunavut Health Care Plan
Telephone: 867-645-8001
Toll free (throughout Canada): 1-800-661-0833
E-mail: nhip@gov.nu.ca
Website:
<http://gov.nu.ca/health/information/nunavut-health-care-plan>
Time limit: 6 months

6.0 Reviewing Claim Results

6.1 Tracking Your Claim

The keys to trouble-free claim submissions are:

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

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

- Prior to assessment, the system checks and validates mandatory fields for accurate data.
- The claim is then assessed in accordance with the Schedule of Medical Benefits and relevant general and assessment rules. The claim is then either paid in full, paid at a reduced rate, paid at zero, refused, or held.

A held claim is assessed manually. Either it will be found valid and processed for payment, applied at “\$0”, or it will be refused. In all cases, it will appear on your Statement of Assessment with a final assessment result.

6.2 Statement of Assessment

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

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

- 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.**



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

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

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

If you are missing any Statement of Assessments within 30 weeks of the issue date, please contact your submitter for electronic assessment result details files. If you are your own submitter and require Statements within 30 weeks of the issue date, contact the H-Link Help Desk at 780-644-7643 (toll-free 310-0000, then 780-644-7643).

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

Section 6.0 – Reviewing Claims Results



Note: Alberta Health will not provide copies of the Statement of Assessment outside 52 weeks of the date the Statement was issued, unless the requester can **provide evidence** that the Statement of Assessment is no longer in their custody or control due to extenuating circumstances. This includes destruction or loss through fire, flood, natural disasters or the theft of paper copies, or the computer where electronic copies were stored.

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

6.3 Statement of Assessment - Sample

E400RS1

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

4 Statement Date: 2013/11/02
Page 1

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

STATEMENT OF ASSESSMENT

5 Reference Nbrs
130509710

865187900

Business Arrangement 9999-999 2
Expected Payment Date 2013/11/09

6 Sequence Nbr
01

10	11	12	13	14	15	16	17	18	19	20	21	
Patient Name	Chart Number	PHN	Claim Number	Service Start Date	Service Code	Claimed Amount	Assessed Amount	Mod Code	Exp Code	Exp Code	Registration Number	RC
7 Boodek, Andrew	8 1992-39000											
9 Banery, Marvin	11 72636-9000	72636-9000	ELA07BA0000793	2013/10/01	03.03A	0.00	24.29				APLY	
Lodger, Beatrice	39053 35D	72685-9010	ELA07BA0000804	2013/10/05	03.05P	0.00	115.25				APLY	
Chipman, Steve	39053-39D	91450-9004	ELA07BA0000708	2013/10/12	10.33A	0.00	36.79				APLY	
Quastell, Loni	39053-21C	92730-9106	ELA07BA0000808	2013/10/11	03.03B	0.00	32.37				APLY	
22 Total Amount to be Paid							208.70					
23 Total Amount (RVSL)							0.00					
7 Doggle, A.C.	8 6843-39000											
Parsill, Judy	23735-9000	23735-9000	ELA07BJ0000806	2013/10/05	48.12	0.00	1484.32				APLY	
Rutlatch, Craig	37735-9000	37735-9000	ELA07BJ0000608	2013/10/09	48.19A	0.00	285.39				APLY	
Owins, Ollie	92649-9000	92649-9000	ELA07BJ0000592	2013/10/12	49.7A	0.00	530.82				APLY	
Total Amount to be Paid							2300.53					
Total Amount (RVSL)							0.00					
24 Summary Total												
25 Provider Name							26 Assessed Amount					
Boodek, Andrew							208.70					
Doggle, A.C.							2300.53					
27 Total Amount to be Paid							2509.23					

6.4 Statement of Assessment – Field Descriptions

To help you understand the Statement of Assessment, please refer to the sample in section 6.3. The main elements on the statement have been numbered. Match the numbers on the sample with the explanations given below.

1. **Statement of Assessment Addressee**
Name and address of the person or organization designated to receive this statement.
2. **Business Arrangement**
Number indicating which business arrangement is to be paid.
3. **Expected Payment Date**
Date on which payment will be issued.
4. **Statement Date**
Date on which the assessment result was produced by Alberta Health.
5. **Reference Numbers**
ID number assigned to the Statement of Assessment produced.
6. **Sequence Number**
Sequential number indicating how many statements have been produced to date for your business arrangement.
7. **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 health service code.
 18. **Result Code**
Code identifying whether a claim is being applied, held or refused.
 19. **Explanatory Code**
Code explaining the reason a claim is being held, reduced, refused or paid-at-zero. RVRSL in this field means the claim has been reassessed and the assessed amount has been changed. (See the Special Processing Codes section in the Explanatory Code Listing.)
 20. **Registration Number**
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).
 22. **Total Amount to be Paid**
Total amount to be paid for services provided by physicians in the business arrangement.
 23. **Total Amount (RVRSL)**
Total amount being recovered from the business arrangement, if payments for previous claims were adjusted.
 24. **Summary Total**
Summary of the amounts payable for services provided by each physician and a grand total amount payable to the business arrangement.
 25. **Provider Name**
Name of each physician within this business arrangement who had claims processed.
 26. **Assessed Amount**
Amount to be paid for each physician's services.
 27. **Total Amount to be Paid**
Total amount to be paid to the business arrangement.

6.5 Result Codes

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

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

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

If you need to correct the data on a paid-at-zero claim or if you disagree with the reason why the claim was paid at zero, you must resubmit the claim with action code C (change) or R (reassess), as applicable. ([See Sections 3.3 - Action Codes](#) and [6.6 - Following up on a Claim – Using the Correct Action Code.](#))

2. **RFSE** (Refuse) means the claim transaction was refused. This is usually due to invalid or missing claim data (such as the patient’s PHN); however, it may be refused for some other reason, such as a general rule or note in the Schedule of Medical Benefits, or an ineligible patient or physician. If you need to correct the data on a refused claim or if you disagree with the reason why the claim was refused, you must submit a new claim using action code A. Your submitter will assign a new claim number to the new submission. ([See Sections 3.3 - Action Codes](#) and [6.6 - Following up on a Claim – Using the Correct Action Code.](#))
3. **HOLD** means the claim is being held, as it requires manual review. A claim on hold will reappear on a future Statement of Assessment with a final assessment outcome. **Do not resubmit a claim while it is on hold.**



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

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

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

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

Claim result

1. The claim was refused (result code RFSE) due to **incorrect** claim data and you want to send a correction.

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.

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.

How to resubmit

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.

Resubmit the claim using the original claim number.

- Use **action code C** (change).
- Complete the base claim segment showing how all the data should now be recorded.

Note: You cannot use action code C to correct a patient PHN, a PRAC ID or a business arrangement number. Delete the original claim and submit a new claim with correct data. Use action code A and a new claim number.

Resubmit the claim using the original claim number.

- c) Use **action code R** (reassess).
- d) Complete the supporting text segment with information to support your reassessment request.
- e) 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.
- Use **action code D** (delete).
 - No base claim data is required.

6.7 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) ([See Appendix A.3 – Obtaining Alberta Health Resource Material](#)).



Note: Alberta Health will not provide copies of the Statement of Account outside 52 weeks of the date the Statement was issued, unless the requester can **provide evidence** that the Statement of Account is no longer in their custody or control due to extenuating circumstances. This includes destruction or loss through fire, flood, natural disasters or the theft of paper copies, or the computer where electronic copies were stored.

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

6.8 Statement of Account - Sample

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

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

Statement of Account

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

Statement Date
Year Month Day
2013 11 09

Method of Payment: EFT

SOA Reference Nbr: 972258640

Payee Dr Andrew Boodek

Expected Payment Date: 2013/11/09

Total Amount: 3298.59

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

Description	Amount
Statement of Assessment	3301.66
Total Amount:	3301.66

6.9 Statement of Account – Field Descriptions

Please refer to section 6.8 and match the numbered elements on the sample statement with the explanations given below.

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

6.10 Monitoring and Compliance

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

To ensure accountability of the AHCIP, the department monitors the health care providers' claims through regular reviews that assess compliance with the applicable legislation. Statistical and risk assessment methodologies are used to identify errors or issues in the claims that were paid under the AHCIP. Subsequently, compliance reviews are triggered for the identified providers. Occasionally, complaints regarding providers' claims are received, and may trigger a compliance review.

Alberta Health's compliance review process typically involves:

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

This compliance review is an interactive process through which providers have the opportunity to provide documentation and comments. In addition, Alberta Health may visit a provider's office to better understand his or her practice and to view patient files. Patients may also be contacted to verify the services that were provided.

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

Misunderstanding of individual items in the schedule or the relevant General Rules may lead to inappropriate claim submission. As detailed in Section 15(2) of the *Alberta Health Care Insurance Regulation*, providers must retain the original documentation relating to the goods or services provided not less than six years and make the documentation available to Alberta Health on request.

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

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

7.0 Schedule of Medical Benefits

The Schedule of Medical Benefits is updated periodically and posted on our website at <http://www.health.alberta.ca/professionals/SOMB.html>. Please check regularly to ensure you are using the most recent edition of the Schedule for your claim submissions.

The Schedule of Medical Benefits 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 health service codes and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.
Price List	Lists all health service codes and their applicable modifiers. This section indicates how fees are modified by specific circumstances. It displays the category code for each service so 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 Schedule of Medical Benefits lists all insured visits, procedures and tests in numerical health service code 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 health service code.

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.

- Roman numerals and description for the anatomical region, e.g., VII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE.
- This field is a heading used to identify body part and type of procedures.
- The NOTE field contains special instructions for a health service code.
- The health service code for the service performed.
- A description of the health service code.
- BASE amount is the fee for the service, before application of any modifiers. This may be a dollar amount or the code BY ASSESS.
- The ANE field indicates the anaesthetic fee for the service.
- 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 health service code.
- BY ASSESS: The fee payable for this procedure depends on supporting information that must be submitted with the claim.

7.2 Procedure List – Sample Page

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

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As of 2014/04/01

Generated 2014/02/11

1 II. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

98.0 Incision of skin and subcutaneous tissue **2**

98.01 Tattooing or insertion into skin and subcutaneous tissue

98.01A Implantation of subdermal contraceptive implant **6** SE 53 **7** NE 27

98.03 Other incision with drainage of skin and subcutaneous tissue

98.03A Incision and drainage of abscess or hematoma, subcutaneous or submucous 31.86 V **8** ;7
NOTE: May be claimed in addition to a visit or a consultation.

98.03B Incision and drainage of abscess, deep, unspecified site **9** ASSESS 108.57
98.03C Aspiration of hematoma 16.82
98.03D Abscess requiring procedural sedation and extensive drainage and packing 100.49
NOTE: May only be claimed when performed in an emergency room, AACC or UCC.

3

98.03E Aspiration of seroma 134.97 121.34

98.04 Incision with removal of foreign body of skin and subcutaneous tissue

98.04A Under anaesthesia 53.97 V 130.16
98.04B Without anaesthesia **5** 27.45
4 98.04C Removal of subdermal contraceptive implant 93.16 107.27

98.1 Excision of skin and subcutaneous tissue

98.11 Debridement of wound or infected tissue
NOTE: Only one of HSCs 98.11A to 98.11F may be claimed per functional or non-functional anatomical area as defined in GRs 7.1.1 and 7.1.2 with the exception of paired structures which may be claimed as two.

98.11A Non-functional area, up to 32 total square cms 102.01 199.05
98.11B Non-functional area, over 32 and up to 64 total square cms 213.77 199.05
98.11C Non-functional area, over 64 total square cms 503.27 217.14
98.11D Functional area, up to 32 total square cms 131.65 108.47
98.11E Functional area, over 32 and up to 64 total square cms 277.12 108.57
98.11F Functional area, over 64 total square cms 654.25 215.00

98.12 Local excision or destruction of lesion or tissue of skin and subcutaneous tissue

98.12A Excisional biopsy, skin 41.25 V 108.57
NOTE: A maximum of three calls may be claimed.

98.12B Excisional biopsy, skin of face 55.21 V 108.57
NOTE: A maximum of three calls may be claimed.

98.12C Removal of sebaceous cyst 52.35 V 108.57
NOTE: 1. May be claimed in addition to a visit or a consultation.
2. A maximum of 3 calls may be claimed.

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7.3 Price List

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

- Description: Warts or Keratoses is the section heading.
- 98.12J is the health service code. See the Procedure List for a description of this code.
- \$21.77 is the base fee for this procedure.
- This field lists all modifier types that apply to this health service code. (98.12J has nine applicable modifier types.)
- A listing of all modifier codes that affect payment, applicable to this health service code. For example:
- A ROLE modifier code entered on a claim indicates the function performed by the physician in providing the service.
- 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.)
- The letter Y in this field identifies each explicit modifier. When applicable, these must be entered on a claim prior to submission.
- This field shows what effect the modifier has on the base amount. Example: When role modifier ANE is entered on a claim for health service code 98.12J, the base amount is replaced by the amount in the next column.
- This field indicates the fee for each modifier code. Example: The ANE fee for health service code 98.12J is \$108.57.
- The category code for each health service code. For example, the letter M identifies the service as a minor procedure.

7.4 Price List – Sample Page

1	2	3	4	5	6	7	8	9
Warts or Keratoses								
98.12J	21.77	BMI	BMIANE	Y	Increase By		25%	M
		BMI	BMIANT	Y	Increase By		25%	
		ROLE	ANE	Y	Replace Base		108.57	
		ROLE	ANEST	Y	Replace Base		18.10	
		ANU	ANU					
			1		For Each Call Pay Base At		100%	
			2-150		For Each Call Increase By		18.10	
		UGA	UGA	Y	Replace Base		134.85	
		CALL	NBRSER					
			1		For Each Call Pay Base At		100%	
			2-3		For Each Call Increase By		8.72	
			4-4		For Each Call Increase By		8.60	
			MAX				47.81	
		TRAY	MAJT		Increase By		37.71	
		NBTR	NBTR	Y				
		LVP	LVP75	Y	Reduce Base To		75%	
98.12K	24.60	BMI	BMIANE	Y	Increase By		25%	M
		BMI	BMIANT	Y	Increase By		25%	
		ROLE	ANE	Y	Replace Base		108.57	
		ROLE	ANEST	Y	Replace Base		18.10	
		ANU	ANU					
			1		For Each Call Pay Base At		100%	
			2-150		For Each Call Increase By		18.10	
		UGA	UGA	Y	Replace Base		134.85	

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7.5 Health Service Codes that Require Supporting Text/Documentation

- | | |
|---------|--------|
| 03.04Q | 08.19H |
| 08.19AA | 08.19J |
| 08.19BB | 08.19K |
| 08.19CC | 13.99J |
| 08.19D | 13.99K |
| 08.19F | |

8.0 Legislation and Regulations

8.1 Canada Health Act

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 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 aim of the act is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services.

For more information visit the Health Canada website at www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php.

The Canada Health Act can be found on the Department of Justice Canada website at <http://laws-lois.justice.gc.ca/eng/acts/C-6/>.

8.2 Alberta Health Act

The *Alberta Health Act* sets out Alberta's commitment to the principles of the *Canada Health Act*. The Act also calls for the adoption of a health charter and a health advocate. The Health Charter sets out the government's commitment to the principles of the *Canada Health Act*. It outlines principles to guide the health system and sets out expectations and responsibilities within the health system. The government has set up a Health Advocate's office, which assists Albertans in navigating the health system.

More information regarding the *Alberta Health Act* can be found online at www.health.alberta.ca/initiatives/Health-Act-Alberta.html.

8.3 Key Alberta Legislation and Regulations

8.3.1 Alberta Health Care Insurance Act

Coverage under Plan

4(2) All claims for benefits are subject to assessment and approval by the Minister and the amount of the benefits to be paid and the person to whom the benefits are to be paid shall be determined in accordance with the regulations.

Payment of benefits

6(1) No physician or dentist may receive the payment of benefits from the Minister for insured services provided in Alberta to a resident unless the physician or dentist was opted into the Plan when the insured services were provided.

(2) No resident may receive the payment of benefits from the Minister for insured services provided in Alberta to the resident by a physician or dentist unless the physician or dentist who provided the insured services was opted into the Plan when the insured services were provided.

(3) Notwithstanding subsections (1) and (2), the Minister may pay benefits for insured services provided in Alberta to a resident by a physician or dentist who was opted out of the Plan if the insured services were provided in an emergency.

Extra billing

9(1) No physician or dentist who is opted into the Plan who provides insured services to a person shall charge or collect from any person an amount in

addition to the benefits payable by the Minister for those insured services.

- (2) If a physician or dentist contravenes subsection (1), the Minister may,
- (a) in the case of a first or subsequent contravention, send a written warning to the physician or dentist,
 - (b) in the case of a 2nd or subsequent contravention, refer the contravention to the College or the Alberta Dental Association and College, as the case may be, and
 - (c) in the case of a 3rd or subsequent contravention, order that, after a date specified in the order, the physician or dentist is deemed to have opted out of the Plan for the period specified in the order.
- (3) An order under subsection (2)(c) shall, prior to the effective date of the order, be served personally or by registered mail on the physician or dentist affected by the order.

Emergency services

10 If a physician or dentist who is opted out of the Plan provides insured services in Alberta in an emergency to a resident in respect of whom benefits may be paid and the physician, dentist or resident is paid benefits with respect to those insured services, the physician or dentist shall not charge or collect

from any person an amount in addition to those benefits.

Minister shall reimburse the person who was charged the amount.

Other prohibited fees

- 11(1) No person shall charge or collect from any person
- (a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan, or
 - (b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan

where the amount is in addition to the benefits payable by the Minister for the insured service.

- (2) Subsection (1) does not prohibit the charging or collecting of an amount paid for non-insured health or pharmaceutical goods or services where the charging or collecting of that amount is not otherwise prohibited under this Act or the Hospitals Act and a physician or dentist reasonably determines that it is necessary to provide the non-insured health or pharmaceutical goods or services before the insured service is provided.
- (3) If a person receives an amount in contravention of subsection (1), the Minister may recover that amount in a civil action in debt as though that amount were a debt owing from the person to the Crown in right of Alberta.
- (4) Where the Minister recovers any amount under subsection (3), the

Prohibition on receiving benefits

- 12(1) A physician or dentist who is opted into the Plan and provides insured services to a person in circumstances where the physician or dentist knows or ought reasonably to know that the person is being charged an amount in contravention of section 11 shall not receive the payment of benefits from the Minister for those insured services.
- (2) Section 9(2) applies where a physician or dentist contravenes subsection (1).

Minister's right to recover amounts

- 13(1) If a physician or dentist
- (a) in contravention of section 9 or 10, receives an amount in addition to the benefits payable by the Minister, or
 - (b) receives the payment of benefits in contravention of section 12, the Minister may act under subsection (2).
- (2) If subsection (1) applies, the Minister may recover the additional amount and the benefits in a case referred to in subsection (1)(a), or the benefits in a case referred to in subsection (1)(b), by one or more of the following means:
 - (a) by withholding those amounts from any benefits payable to the physician or dentist;
 - (b) by civil action as though those amounts were a debt owing to the Crown in right of Alberta;
 - (c) pursuant to any agreement between the Minister and the physician or dentist that

- provides for the repayment of those amounts.
- (3) The Minister shall reimburse a person in respect of whom benefits may be paid for any amounts recovered under this section that were paid by the person and have not been previously reimbursed.

Offence

- 14 A person who contravenes section 9, 10, 11 or 12 is guilty of an offence and liable to a fine of not more than
- (a) \$10 000 for the first offence, and
 - (b) \$20 000 for the 2nd and each subsequent offence.

Duty to advise

- 15(1) Prior to providing insured services in Alberta to a resident in respect of whom benefits may be paid, a physician or dentist who is opted out of the Plan shall advise the resident of that fact and that the resident is not entitled to be reimbursed from the Plan for the cost of any insured services provided by the physician or dentist.
- (2) This section does not apply when the insured services are provided in an emergency.

Regulations

- 17 The Minister may make regulations
- (a) respecting the rates of benefits in respect of basic health services or extended health services;
 - (b) respecting the manner in which benefits are to be paid and the persons to whom benefits are to be paid, the conditions of payment and the information required to be

submitted in connection with claims for benefits;

- (c) specifying, within the classes prescribed by the Lieutenant Governor in Council, the goods and services that are basic health services or extended health services for the purpose of the Plan.

Reassessment of claims

- 18(1) The Minister may, with respect to any claim for benefits that has been assessed under section 4(2), reassess the claim if the payment or rejection of the claim was made in error or as a result of erroneous or false information provided by the resident or practitioner concerned or by any other person acting on behalf of the resident or practitioner concerned.
- (2) The Minister may, with respect to any claim for benefits, reassess the claim when, in the opinion of the Minister,
- (a) the claim relates to a health service of a kind that the practitioner concerned has provided to the practitioner's patients with a frequency that, in the circumstances, is unjustifiable,
 - (b) the total amount of benefits paid for the service was, in the circumstances, greater compensation to the practitioner for that service than it should have been,
 - (c) the service provided was, in the circumstances, inappropriate or unnecessary,
 - (d) the service provided could have been replaced by another professionally acceptable service

- for which a lower rate of benefits was payable, or
- (e) in the case of a service provided by a physician, the service was not medically required.
- (3) In reassessing claims pursuant to subsection (2), the Minister shall have regard to all the circumstances that, without limitation, shall include
- (a) normal patterns of practice in Alberta of practitioners of the same profession who carry on similar types of practice in similar circumstances;
- (b) accepted standards of practice in Alberta of the profession of the practitioner concerned;
- (c) in cases referred to in subsection (2)(b), the amount that would have been reasonable compensation for the service provided, in view of the time and degree of skill involved in providing the service.
- (4) When reassessing a claim under subsection (2), the Minister may
- (a) establish a committee to prepare a report or make recommendations respecting the reassessment and may select and appoint persons from the roster established under subsection (4.1) as members of the committee, and
- (b) have regard to any report or recommendations of the committee.
- (4.1) The Minister may establish a roster of practitioners and members of the public who may be appointed to committees established under subsection (4).
- (5) When the Minister reassesses claims pursuant to subsection (1) or (2), the Minister may make any appropriate adjustment in the amounts paid with respect to the claim and
- (a) if the amounts paid were in excess of the benefits payable under the adjustment, recover the excess from the resident or the practitioner, as the case may be,
- (i) by withholding from any benefits payable to the resident or the practitioner, as the case may be, an amount equivalent to the excess,
- (ii) by civil action as though the excess were a debt owing to the Crown in right of Alberta, or
- (iii) pursuant to an agreement between the Minister and the resident or practitioner concerned providing for the payment of the excess;
- (b) if the amounts paid were less than the benefits payable under the adjustment, pay to the resident or the practitioner to whom the benefits were paid, as the case may be, the amount of the deficiency.
- (6) The Minister may, with respect to any excess or deficiency referred to in subsection (5), charge or pay simple interest at a rate the Minister determines but not exceeding 8% per year.
- (7) The Minister may withhold benefits payable to a practitioner or a resident until the completion of a reassessment under subsection (1) or (2) of claims relating to services provided by that practitioner.
- (8) The Minister shall notify the resident or practitioner concerned by mail of any

reassessment under this section and the person so notified may appeal the reassessment to the Court of Queen's Bench by way of application if the application is returnable within 60 days after the date on which that person was notified.

Crown's right of recovery

25 The Crown in right of Alberta is entitled to recover the Crown's cost of health services under the Crown's Right of Recovery Act.

Examination of practitioner's records

39(1) A person employed in the administration of this Act who is expressly authorized to do so by the Minister may, for the purpose of conducting an examination and audit of the claims for or payments of benefits relating to health services provided by a practitioner or group of practitioners,

- (a) enter the premises of the practitioner or group of practitioners, and
- (b) examine and audit any books, accounts, patient records or other records that are maintained by or on behalf of the practitioner or group of practitioners.

(2) A person conducting an examination and audit under subsection (1) may

- (a) take extracts from or make copies of all or any part of the books,

accounts and records referred to in subsection (1)(b), and

- (b) make inquiries of the practitioner or the members of the group of practitioners respecting the claims, payments and health services.

(3) A practitioner and each member of a group of practitioners shall provide a person who has been authorized by the Minister under subsection (1) with access to the premises and to the books, accounts and records referred to in that subsection and shall answer the person's inquiries respecting the claims, payments and health services.

(4) If a practitioner or a member of a group of practitioners fails or refuses to provide access to premises or to books, accounts or records or fails or refuses to answer inquiries as required by subsection (3), the Minister, after advising the council of the College or the board of directors or council of the organization that represents the practitioner's profession of the failure or refusal, may withhold the payment of benefits to that practitioner in respect of claims made by that practitioner on behalf of residents until the access is provided or the answers are given.

8.3.2 Alberta Health Care Insurance Regulation

Benefits payable re extended health services

- 12(2) Unless otherwise approved by the Minister, the following services are not basic health services or extended health services:
- (a) medical-legal services, including
 - (i) examinations performed at the request of third parties in connection with legal proceedings,
 - (ii) giving of evidence by a practitioner in legal proceedings, or
 - (iii) preparation of reports or other documents relating to the results of a practitioner's examination for use in legal proceedings or otherwise and whether requested by the patient or by a third party;
 - (b) advice by telephone or any other means of telecommunication and toll charges or other charges for telephone calls or telecommunication services except as provided for in the Schedule of Medical Benefits under the Medical Benefits Regulation;
 - (c) transportation services, including ambulance services for
 - (i) transportation of a patient to a hospital or to a practitioner elsewhere, or
 - (ii) transportation of a practitioner to a hospital or to a patient elsewhere, whether the costs of those services are by way of charges for distance or charges for travelling time;
 - (d) examinations required for the use of third parties;
 - (e) services that a resident is eligible to receive under a statute of any other province or territory, the Health Care Protection Act, the Hospitals Act, any statute relating to workers' compensation or under any statute of the Parliament of Canada, including
 - (i) the Aeronautics Act (Canada),
 - (ii) the Civilian War-related Benefits Act (Canada),
 - (iii) the Corrections and Conditional Release Act (Canada),
 - (iv) the Government Employees Compensation Act (Canada),
 - (v) the Merchant Seamen Compensation Act (Canada),
 - (vi) the National Defence Act (Canada),
 - (vii) the Pension Act (Canada), and
 - (viii) the Royal Canadian Mounted Police Act (Canada);
 - (f) services not provided by or under the supervision of a practitioner, except as provided for in the Schedule of Medical Benefits under the Medical Benefits Regulation;
 - (g) services for which a patient would not be liable to pay in the absence of benefits for health services;
 - (h) services that the Minister, on review of the evidence, determines not to be health services because the services
 - (i) are not required, or
 - (ii) are experimental or applied research;

- (i) services in connection with group immunizations against a disease or services in connection with group examinations by a practitioner;
 - (j) services provided by a practitioner to the practitioner's children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner or any person who is dependent on the practitioner for support;
 - (k) laboratory and diagnostic imaging services provided in Alberta in a facility that does not meet the criteria for registration under the Alberta Health Care Insurance Plan and that is not registered with the Alberta Health Care Insurance Plan or for which benefits are not payable under the Medical Benefits Regulation, the Podiatric Surgery Benefits Regulation, the Podiatric Benefits Regulation or the Oral and Maxillofacial Surgery Benefits Regulation;
 - (l) services provided outside Canada that are available inside Canada (other than services provided in the case of an emergency);
 - (m) services provided outside Canada that are not available inside Canada unless approved by the Out-of-Country Health Services Committee or the Out-of-Country Health Services Appeal Panel under the Out-of-Country Health Services Regulation;
 - (n) drugs, casts, surgical appliances and special bandages, except as provided for in the Schedule of Medical Benefits under the Medical Benefits Regulation, the Schedule of Podiatric Surgery Benefits under the Podiatric Surgery Benefits Regulation or the Schedule of Podiatric Benefits under the Podiatric Benefits Regulation;
 - (o) associated with any health services provided in a non-hospital facility outside of Alberta;
 - (p) services for substance abuse, eating disorders or other addictive disorders provided outside of Alberta.
- Diagnostic imaging services**
- 13(1) If benefits are paid or payable with respect to diagnostic imaging services provided to a resident, the practitioner who provided the services shall, as soon as is reasonably practicable after a request is made by the resident, make the resulting diagnostic images available to any other practitioner designated by the resident.
- (2) A practitioner who receives diagnostic images under subsection (1)
- (a) may make copies of the images, and
 - (b) shall, as soon as is reasonably practicable after the images have served the purpose for which they were required, return the original images to the practitioner who made the images available.
- (3) If a practitioner fails to comply with a request under subsection (1),
- (a) the Minister may withhold the benefits payable to the practitioner with respect to the diagnostic imaging services provided to the resident, or
 - (b) if benefits have already been paid to the practitioner or resident with respect to those services, the practitioner is liable for and shall

Section 8.0 – Legislation and Regulations

- repay to the Minister the benefits paid in respect of the services.
- (4) If the practitioner fails to repay benefits under subsection (3)(b), the Minister may withhold the amount of the benefits from any other benefits payable to the practitioner.
- (5) If a practitioner fails to comply with subsection (2)(b), the Minister may withhold from benefits payable to the practitioner an amount equivalent to the benefits paid or payable with respect to the diagnostic imaging services provided by the practitioner who made the diagnostic images available.
- (6) If benefits are withheld by the Minister under subsection (3)(a), (4) or (5) or a practitioner repays benefits to the Minister under subsection (3)(b), the practitioner is not entitled to collect any amount from any person in respect of the services involved.
- (2) A person who contravenes subsection (1) is guilty of an offence.
- (3) To avoid any doubt, for the purpose of the Act and regulations, any good or service provided by a practitioner that is listed in the Schedule of Medical Benefits under the Medical Benefits Regulation, the Schedule of Podiatric Surgery Benefits under the Podiatric Surgery benefits Regulation or the Schedule of Oral and Maxillofacial Surgery Benefits under the Oral and Maxillofacial Surgery Benefits Regulation is an insured service, whether the cost of that good or service is greater than or less than the maximum benefit payable for that good or service provided.

Information to be provided by practitioners

Extra Billing

- 14(1) Except as provided for in section 21 of the Act, a practitioner must not submit an account for payment to a resident or to another Government department or agency if the practitioner has submitted or intends to submit a claim for benefits to the Minister.
- 15(1) A practitioner must, in a form approved by the Minister, provide to the Minister any information that the Minister may require regarding the practitioner's training, the type of practice the practitioner is engaged in or any other related information.
- (2) If a practitioner provides goods or services to a resident of Alberta, the practitioner must retain the original documentation relating to the goods or services provided for a period of not less than 6 years and must, on request, make the documentation available to the Minister.

8.3.3 Claims for Benefits Regulation

To whom benefits are payable

3(1) Subject to subsection (4), the Minister may, in respect of a health service provided in Alberta to a resident or to a resident’s dependant who is a resident, pay benefits to

- (a) the resident,
- (b) the practitioner who provided the health service, or
- (c) a third party who at the request of the Minister
 - (i) provides evidence satisfactory to the Minister that he or she paid for the health service provided, or
 - (ii) has entered into an agreement with the Minister for the reimbursement of benefits paid by the third party.

(2) Subject to subsection (4), the Minister may, in respect of a health service provided outside Alberta in another province or a territory of Canada to a resident or to a resident’s dependant who is a resident, pay benefits to

- (a) the resident,
- (b) the resident’s insurer, if the insurer
 - (i) provides evidence satisfactory to the Minister that the insurer paid for the health service provided, or
 - (ii) has entered into an agreement with the Minister for the reimbursement of benefits paid by the insurer,

- (c) the practitioner who provided the health service,
- (d) a health care facility,
- (e) the government of a province or territory in Canada, as the case may be, or
- (f) a third party who is not an insurer and who at the request of the Minister
 - (i) provides evidence satisfactory to the Minister that the third party paid for the health service provided, or
 - (ii) has entered into an agreement with the Minister for the reimbursement of benefits paid by the third party.

Payment to practitioner

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.

Form of claim

5(1) A claim for benefits must include the information required by the Minister and must be submitted in a manner determined by the Minister.

(2) When a person has submitted a claim for benefits, the person must provide to the Minister, in a manner determined by the Minister, any further information

respecting the claim that the Minister requires.

Adjustment of claim permitted

6 If a person has received payment from the Minister with respect to a claim or claims for benefits and subsequently requests adjustment in the amount paid because of an error, the Minister may make the adjustment.

Limitation period for claims

7(1) Unless the Minister considers that extenuating circumstances exist, a claim for benefits for health services provided to a resident is not payable

- (a) if the Minister receives the claim from a practitioner in Alberta more than 180 days after the date the health service was provided or the resident was discharged from hospital, or

- (b) if the Minister receives the claim from a resident, a practitioner outside Alberta or a health care facility outside Alberta more than 365 days after the date the service was provided or the resident was discharged from hospital.

(2) Unless the Minister considers that extenuating circumstances exist, a claim for benefits for health services provided in Alberta that is resubmitted for payment is not payable if it is submitted more than 180 days after the last transaction for that claim.

(3) Subsections (1) and (2) do not apply in respect of a claim submitted or resubmitted pursuant to an agreement referred to in section 17 of the Alberta Health Care Insurance Regulation.

8.3.4 Medical Benefits Regulation

Benefits for services in Alberta

3(1) The benefits payable for insured medical services provided to a resident of Alberta in Alberta and the descriptions of those services are set out in the Schedule of Medical Benefits.

(2) Notwithstanding subsection (1), unless otherwise approved by the Minister, the benefits payable for insured medical services provided to a resident of Alberta in Alberta are limited to the lesser of

- a) the amount claimed, and
- b) the rates established in the Schedule of Medical Benefits.

Included in amount of benefits

6 The benefits payable for insured medical services provided to a resident of Alberta by a physician include an amount for the following

- a) performing the insured medical service;
- b) administration;
- c) recording of information regarding the services provided unless the recording of the information is for the purposes of a third party;
- d) completing and submitting claims;
- e) discussion or correspondence with a referring health care professional regarding treatment or a service to

be provided to a patient directly related to managing the patient's care, unless otherwise provided in this Regulation or the Alberta Health Care Insurance Regulation.

Conditional benefits

7 Benefits are not payable for pathology services or diagnostic imaging services provided to a resident of Alberta in Alberta unless the physician that provides the insured medical service has been accredited to provide the insured medical service by the College of Physicians and Surgeons of Alberta.

Alteration of appearance surgery

8 No benefit is payable with respect to a surgical procedure for the alteration of appearance performed for emotional, psychological or psychiatric reasons unless the Minister gives approval prior to the surgery being performed.

Specialist benefits

9(1) Specialist benefits for insured medical services provided in Alberta are payable only to a physician who has received

a) a specialist certificate in accordance with the Medical Profession Act, or

b) an interim certificate issued by the College of Physicians and Surgeons of Alberta indicating that the physician has completed the requirements for a specialist certificate and is awaiting formal recognition.

(2) Specialist benefits for insured medical services provided to a resident of Alberta in a place outside of Alberta are payable only if the physician who provided the insured medical services is accredited as a specialist in that place.

Rates set by regional health authority

10(1) The benefits payable for laboratory medicine services and pathology services provided to a resident of Alberta in Alberta are the rates determined by the regional health authority of the health region in which the services are provided.

(2) The benefits referred to in subsection (1) are not payable unless the service is provided by a person authorized by a regional health authority to provide the service.

APPENDICES

Superseded

Appendix A – Contact Information and Resources

A.1 Alberta Health Contact Information

Mailing address

Correspondence can be mailed to:

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

Telephone

Information about:

- Claim assessment or reassessments, including medical reciprocal claims **780-422-1600**
(8:15 a.m. – 4:30 p.m.)
- General billing inquiries **Do not give out this number** to the general public
- Maximum of three issues per call

Information about:

- Practitioner or facility registration **780-422-1522**
(8:15 a.m. – 4:30 p.m.)
- Changes to address, skill, business arrangement **Do not give out this number** to the general public
- Direct deposit, banking information

Obtain PHNs for patients who do not have their Alberta personal health card or number with them at the time of service

- Maximum of three PHNs per call

780-415-2288

(8:15 a.m. – 4:30 p.m.)

Do not give out this number to the general public

Appendix A – Contact Information and Resources

Check an Alberta patient's PHN and/or its status for a specific date

780-422-6257

Toll-free **1-888-422-6257**

(24 hour access - automated service, no access to staff.)

Do not give out this number to the general public

Information about:

- H-Link submitter accreditation
- Application support

780-644-7643

(8:15 a.m. – 4:30 p.m.)

Do not give out this number to the general public

Request a replacement Statement of Assessment

780-415-8731

(24 hour access)

- 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

The public also uses this number to request other information.

General inquiries about AHCIP coverage and benefits

780-427-1432

(8:15 a.m. – 4:30 p.m.)

The public also uses this number to request information.

A.2 Alberta Health Resources

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

1. Schedule of Medical Benefits
2. Physician's Resource Guide
3. Bulletins
4. Interactive voice response (IVR) system
5. Diagnostic Code Supplement (ICD9)
6. Facility Listing
7. Statement of Assessment and Statement of Account

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.

A.3 Obtaining Alberta Health Resource Material

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

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



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

3. The Schedule of Medical Benefits, Diagnostic Code Supplement (ICD9), Explanatory Code List, Facility Listing and Physician's Resource Guide are located at www.health.alberta.ca/professionals/fees.html.

4. Bulletins, which contain information about Schedule of Medical Benefits amendments and advice regarding claim submissions, clarification of assessment, etc., are produced as necessary and posted at www.health.alberta.ca/professionals/bulletins.html.



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

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

A.4 Obtaining Alberta Health Legislation and Regulations

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

- Alberta Health: www.health.alberta.ca/about/health-legislation.html
- Alberta Queen's Printer: www.qp.alberta.ca

Appendix B – Billing Tips

B.1 Alberta Claims

Visits and

consultations:

- Health service codes for these services are found under the “Clinical Evaluation and Examination” section in the Procedure List and Price List in the Schedule of Medical Benefits.
- General 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 15.3 in the Schedule.
- 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 general rule 5.2 in the Schedule and the notes following health service code 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 general 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 general rule 5.1.1 in the Schedule.

- LEVL:**
- This implicit modifier refers to the variation in payment for health service code 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 general 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 health service codes 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:

- General rule 14 in the Schedule lists the health service codes 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 automatically be modified to deduct tray services.

B.2 Medical Reciprocal Claims

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.
- 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 health service code is greater than the maximum indicated in the Price List of the Schedule of Medical Benefits.



Note: 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.

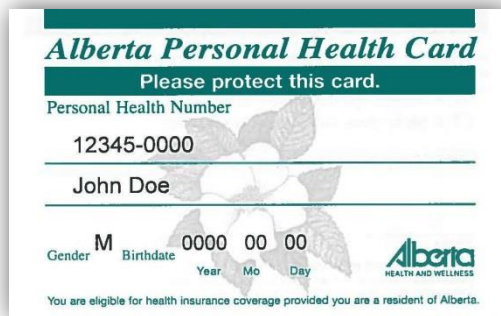
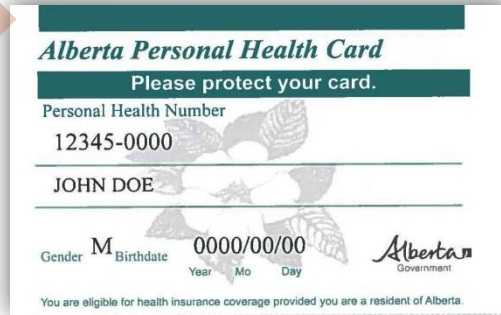
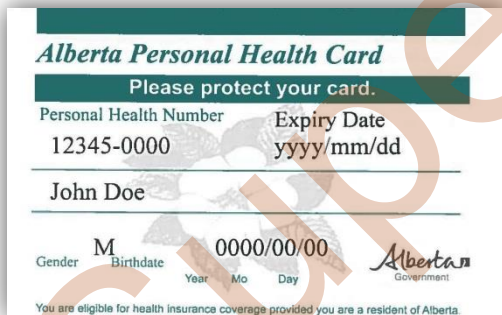
Appendix C – Valid Provincial/Territorial Health Cards



Note: Alberta Health does not provide copies of the Provincial/Territorial Health Care Card Poster. As revised versions of the poster are released by Health Canada, they are posted on the Alberta Health website at www.health.alberta.ca/professionals/resources.html

ALBERTA

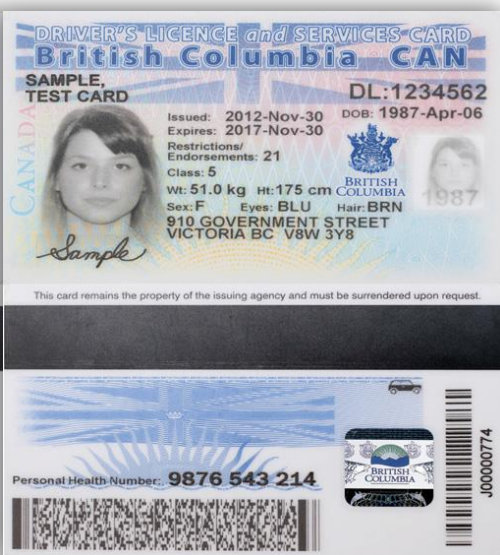
- Alberta personal health cards are not issued annually. New residents and newborns are issued cards when they are registered.
- Replacement cards are issued upon request.
- Information on the card includes the individual’s nine-digit personal health number (PHN), name, gender and date of birth.
- Personal 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.



BRITISH COLUMBIA

Recovery Code – BC

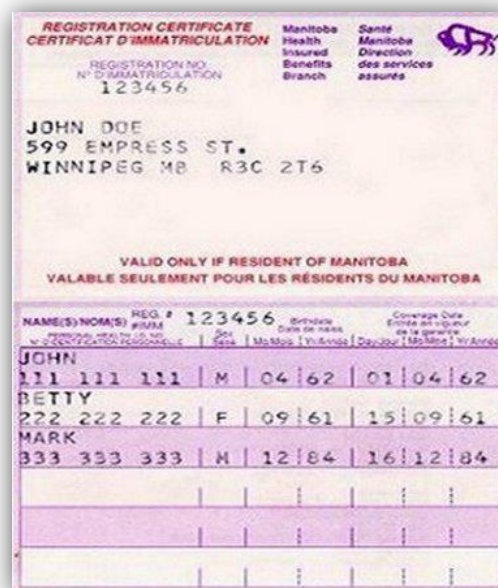
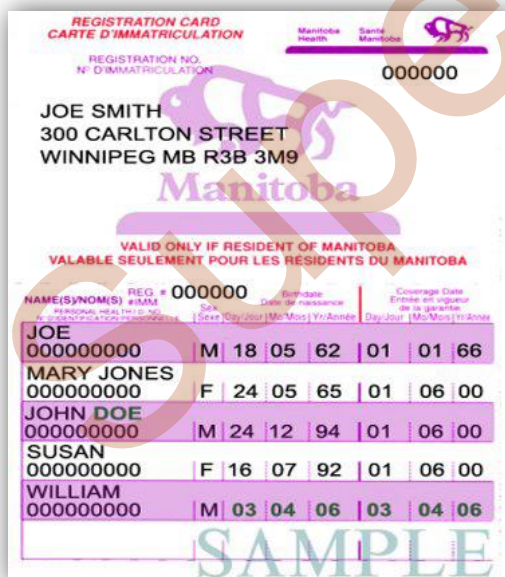
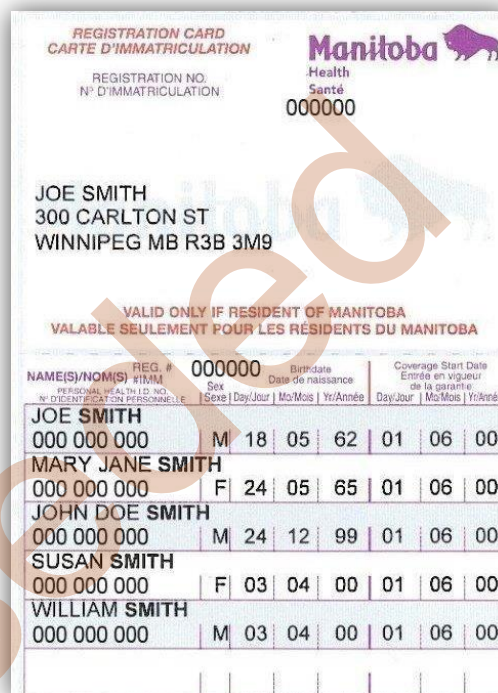
- The regular card is on a white background with the word “CareCard” filling the background in grey.
- The words “British Columbia Care” are blue and “Card” is red. The flag is red, blue, white and yellow. Plan member information is in black.
- A gold CareCard is issued to seniors a few weeks before they reach age 65. It is gold with the words “British Columbia CareCard FOR SENIORS” in white. Plan information is also in white.
- On February 15, 2013, the B.C. provincial government introduced the BC Services Card, which will be phased in over a five-year period. The new card replaces the CareCard. It is secure government-issued identification that British Columbians can use to prove their identity and access provincially-funded health services.



MANITOBA

Recovery Code – MB

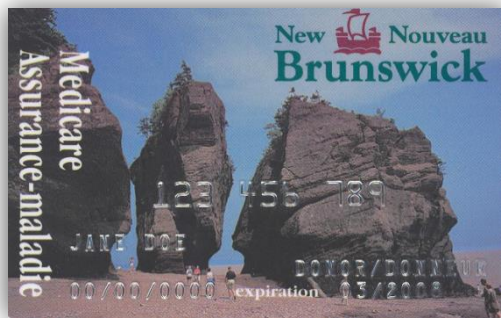
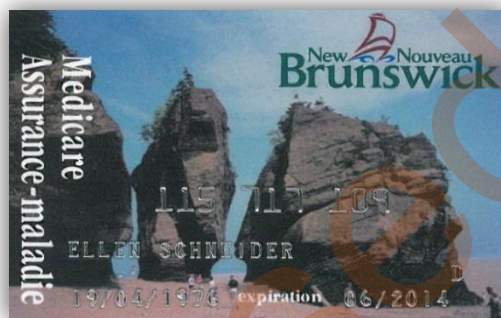
2. Manitoba Health issues a card (or registration certificate) to all Manitoba residents.
3. It includes a nine-digit lifetime identification number for each family member.
4. The white paper card has purple and red print, and includes the previous six-digit family or single person’s registration number, 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

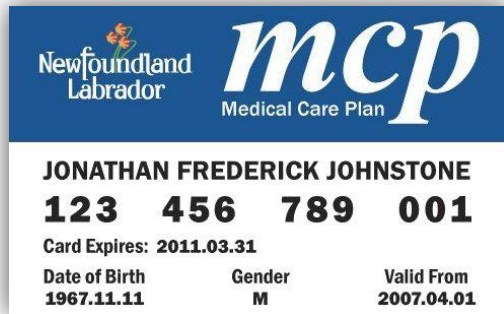
5. The plastic card with a magnetic strip depicts a New Brunswick scene of the Flowerpot Rocks-Hopewell Cape.
6. The New Brunswick logo is displayed in the upper right corner.
7. The card contains the nine-digit Medicare registration number, the subscriber's name, date of birth and expiry date of the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



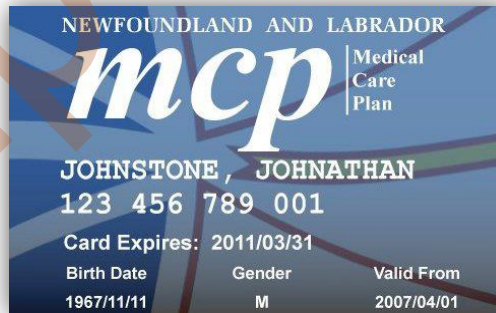
NEW FOUNDLAND AND LABRADOR

Recovery Code – NL

- The MCP cards contain an individual’s name, gender, MCP number and birth date.
- The cards have an expiry date to allow the Department of Health and Community Services to periodically update the MCP database and provide an improved mechanism for accountability. New cards issued this year include a bar code.



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



NORTHWEST TERRITORIES

Recovery Code – NT

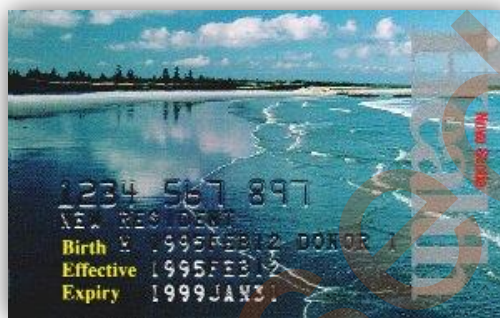
- A new health care card for NWT came into effect in February 2016 showing the new visual elements of the Government of the NWT.
- The new health care card does not affect the NWT residents' health care coverage.
- The old NWT health card, which features a northern landscape as a faint background screen,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



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/mm/dd.



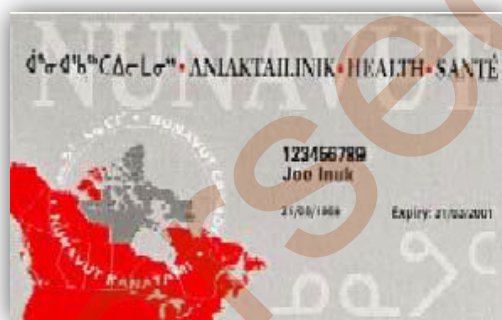
Note: Nova Scotia issues a health card that is valid only in Nova Scotia. Persons entering Nova Scotia with a work or student visa may be provided temporary coverage for insured health services. The card clearly states that coverage is valid only in the province of Nova Scotia



NUNAVUT

Recovery Code – NU

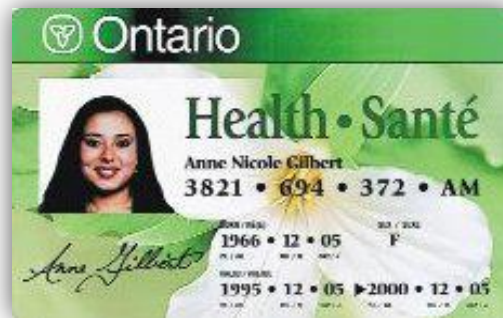
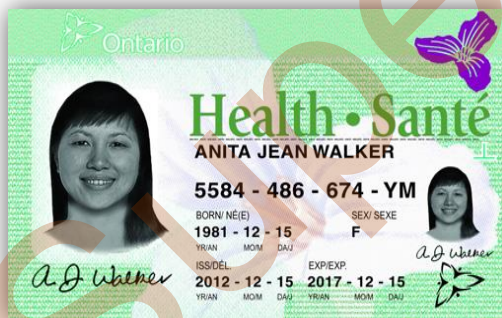
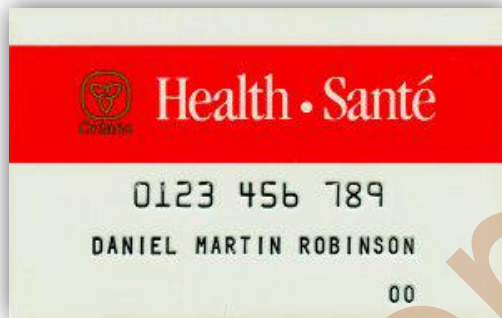
- The Nunavut health card is made of pale grey plastic.
- It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages.
- In the upper portion of the card the word NUNAVUT appears 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

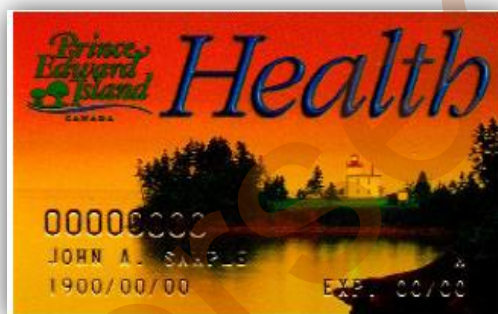
- Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services, provided they are valid and belong to the person presenting the card.
- The red and white health card shows the Personal Health Number and name.
- The photo 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.
- 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 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

- The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan.
- Cards issued to persons not required to provide a photo and a signature, such as children under age 14, have no photo or signature spaces, while cards issued to persons exempt from providing their photo, their signature or both, are marked "exempté" in the appropriate space(s.)



SASKATCHEWAN

Recovery Code – SK

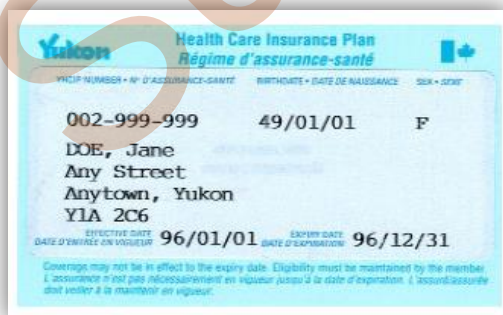
- The plastic cards are blue above and grey below a green, yellow and white stripe.
- Cards contain a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, beneficiary's month and year of birth and eight-digit Family/Beneficiary number.



YUKON

Recovery Code – YT

- The plastic cards are light blue in color with dark blue print.
- A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card.
- The green health care card entitles holders to all seniors' benefits, hospital and physician services. Persons are eligible for the card if they are a Yukon resident aged 65 years or older, or if they are 60 years of age or older and married to a living Yukon resident who is 65 years of age or older.



Appendix D – 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 Schedule of Medical Benefits. This is not allowed under section 9(1) of the *Alberta Health Care Insurance Act*.

Basic health benefits

Services deemed medically required according to the *Canada Health Act* and provided by 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.

By assessment

A specific procedure with a health service code 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.

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. A diagnostic code must appear on all AHCIP medical claims.

Direct billing

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

Direct deposit (or electronic funds transfer)

The method by which AHCIP benefit payments are transferred directly into a practitioner's, organization's or professional corporation's bank account.

Discipline

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

Electronic claim submission

The method used to submit claims electronically to the Alberta Health mainframe. In-province 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 health service code to increase or decrease the base payment amount for a health service. Modifiers are explicit or implicit. Explicit modifiers are entered by the 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.

Good faith policy

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

Governing organization

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

Health service code

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. (See PHN.)

Unlisted procedure

A procedure that does not have a health service code 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 health service code changes. Example: A plastic surgeon's consultation fee varies (is paid at a different rate) as compared with that of an internal medicine specialist.

Superseded