

Alberta Health and Wellness

Allied Health Practitioner's Resource Guide

For allied health practitioners and their office staff

How to handle fee-for-service claims to the
Alberta Health Care Insurance Plan

August 2011

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

Please feel free to make copies of this Resource Guide as needed

Government
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List of August 2011 changes to the Allied Health Practitioner's Resource Guide

- Added Section 5.5 Prior approval for health care services provided outside Canada

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Introduction

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

- Understand what must be included on all claims to the AHCIP,
- Ensure that data you enter on a claim is up-to-date,
- Verify a patient's health care coverage, and
- Understand the Alberta Health and Wellness Statement of Assessment and Statement of Account.

This guide is designed for use with your Schedule of Benefits, which consists of these sections:

General Rules: Defines the circumstances under which insured services are paid.

Procedure List: Lists insured services. This section contains health service codes and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.

Price List: Lists all health service codes and their applicable modifiers. This section indicates how fees are modified by specific circumstances. It displays the category code for each service so practitioners can identify visits, tests, minor and major procedures, where applicable.

Fee Modifier Definitions: Describes all implicit and explicit modifier codes used by the AHCIP processing system to determine amounts payable.

A current copy of your Schedule of Benefits is available in two formats for your reference:

- On our website at www.health.alberta.ca/professionals/fees.html
- CD-ROM

New practitioners are issued a current copy of the Schedule on CD-ROM free of charge upon request. Whenever the Schedule is updated, the new version is posted on our website for your use. If you need an updated copy on CD-ROM, you can fax a request to 780-427-1093. Be sure to include your PRAC ID with your request.

Alberta Health and Wellness also provides the following reference documents to assist you with your claim submissions:

Explanatory Code List: Provides explanations about why the AHCIP has reduced a claim payment, paid a claim at zero, refused or otherwise changed a claim. This list is normally included in the Schedule of Benefits.

Diagnostic Code Supplement: Itemizes diagnosis for services performed. (See **3.4.1 In-province provider base claim segment** for more information about diagnostic codes.)

Facility Listing: Lists the facility numbers and functional centre codes for Alberta's general (active treatment) and auxiliary hospitals, nursing homes, community mental health clinics, correctional centres and community ambulatory centres. Identifies the **physical location** where health services are performed. (See **7.1 Glossary** for definitions of these facilities.)

A facility number or a location code must appear on all claims to the AHCIP.

The Facility Listing does not include facility numbers for office, clinic, diagnostic or laboratory locations. These are assigned by Alberta Health and Wellness and provided to the facility staff or practitioner who requested the number.

CDs of these reference documents can be obtained by faxing a request to 780-427-1093. They are also on our website at www.health.alberta.ca/professionals/fees.html.



Note: The practitioner reference documents (Schedules of Benefits, listings, forms, etc.) available on our website require Adobe Acrobat PDF software to be viewed. This software is available free of charge from Adobe via links on the web pages where these documents are displayed.

Alberta Health and Wellness also periodically issues Bulletins to highlight or clarify changes relating to claim submissions and assessments and/or to provide practitioners with other important information. We encourage you to share these Bulletins with your office/billing staff.

As with this Allied Health Practitioner's Resource Guide, information in a Bulletin may be subject to legislation and policy changes. In the event of conflict between Bulletin information and any applicable legislation or policy, the legislation/policy will prevail.

1.0 AHCIP basics for the practitioner

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

The Professional and Facility Management unit of Alberta Health and Wellness handles applications for PRAC IDs and maintains the related information (business arrangements, skills, addresses, etc.) that is vital to processing practitioner claims.

1.1 Claiming services from AHCIP

Practitioners may submit claims to the AHCIP for insured services provided to eligible Alberta residents. They may claim payment from the AHCIP directly, or they may bill the patient.

Claims are submitted to the AHCIP through an existing accredited submitter, using the electronic H-Link method. Alternatively, the practitioner can apply to become their own submitter.

1.2 Services not claimable from AHCIP

- Services that are not insured may not be claimed from the AHCIP.
- Practitioners may not claim for any service they provide to their children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner, or any person who is dependent on the practitioner for support.
- When one practitioner sends a member of his/her family to another practitioner, the second practitioner may not claim for a consultation. A referral from a patient's family member is not considered a formal referral for the purposes of billing a consultation service.
- Claims that are the responsibility of the Workers' Compensation Board (WCB) are not to be submitted to the AHCIP. They should be submitted directly to the WCB. (See **5.4 Workers' Compensation Board (WCB) claims.**)

1.3 Registering as a new practitioner

A practitioner registering with Alberta Health and Wellness for the first time must complete a Practitioner Information form - AHC0912. When registered, the new practitioner is assigned a Practitioner Identification number (PRAC ID).

The PRAC ID is entered on a claim to the AHCIP to identify the practitioner who provided the service. When applicable, it also identifies the practitioner who has referred a patient to another practitioner for an insured service.

Instructions for completing the AHC0912 form: (See 1.10 Form samples.)

- Section A:** **New practitioner registration** – Complete as applicable.
- Section B:** **Identification** – Complete all areas.
- Section C:** **Organization information** – Complete this section if you want to set up a business arrangement in a name other than your own, such as a professional corporation or clinic. Payments will be directed to the corporation/clinic. If you are a professional corporation, you will need to attach a copy of the Certificate of Incorporation as provided by your licensing body.
- Section D:** **Education, professional association registration and specialties/certifications** – Complete all applicable areas. Be sure to attach the applicable documentation as indicated at the top of this section.
- 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 1.5 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.
- 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 and Wellness can assist you in determining whether a new facility number is required.
- Section H:** **Authorization** – The practitioner must sign and date this section before this form is considered valid.



Note: If you are a **salaried or contract practitioner** who does not submit claims to the AHCIP but refers patients to practitioners who do bill the AHCIP, you should still register as a referring practitioner. Simply complete sections A, B, D and H of the Practitioner Information form – AHC0912, and be sure to attach all required documentation. No other forms are required.

1.4 Other forms a practitioner may need to complete

A practitioner who is already registered and needs to change some of the information about their practice (business mailing address, business arrangement, skill, submitter, banking information, etc.) will need to complete one or more of the forms listed below. (See **1.10 Form samples**.)

Facility Registration:

AHC0910A

To set up a new facility, or if you are moving to a new site that is not yet registered with Alberta Health and Wellness.

Organization Information:

AHC0911

To register a professional corporation or clinic.

Business Arrangement Request:

AHC0913

To set up a new business arrangement, change information on an existing business arrangement, or end an existing business arrangement.

Business Arrangement/Service Provider Relationship:

AHC0914

To be added to an existing business arrangement, or to change information about your relationship with an existing business arrangement.

Electronic Funds Transfer Request:

AHC1143

To change the direct deposit banking information for your claim payments.

Application for Submitter Role:

AHC2095

To apply to be your own submitter.

Submitter/Client Relationship for Electronic Claim Submission:

AHC2096

To authorize an accredited submitter to submit claims on your behalf, or to change from one submitter to another.



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

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

1.5 The business arrangement

To submit claims for insured services, a practitioner must have or be part of a business arrangement with Alberta Health and Wellness. 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 and Wellness statements are to be sent.
- Which submitter is authorized to submit claims for that business arrangement.

A business arrangement number must appear on all claim submissions. A practitioner registering with Alberta Health and Wellness for the first time provides their business arrangement details when they complete section E on the Practitioner Information form - AHC0912.

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

To make a change to an existing business arrangement or to request a new business arrangement, complete a Business Arrangement Request form - AHC0913. (See **1.10 Form samples**.)

1.5.1 The business arrangement and the practitioner's professional corporation

If you are a professional corporation, your Alberta Health and Wellness 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 Wellness and must have a business arrangement. You will need to complete the following forms:

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

1.5.2 The business arrangement and the practitioner's default skill

The default skill is the primary skill used by the practitioner to perform all or most services. Practitioners with multiple skills must designate a default skill for claim submission purposes.

- A new practitioner with more than one skill indicates their default skill (i.e., which skill will be used on most claims) when completing section E on the Practitioner Information form - AHC0912.
- As applicable, practitioners completing the Business Arrangement Request - AHC0913 and Business Arrangement (BA)/Service Provider (SP) Relationship - AHC0914 forms also indicate their default skill.

When the Skill Code field on a claim to the AHCIP is left blank, the claim is automatically processed using the default skill. (See **3.4.1 In-province provider base claim segment** for more information about skill codes.)

1.5.3 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 and Wellness. This ensures payments are deposited into the correct account in a timely manner.

- When a new practitioner is setting up a new business arrangement, they provide their direct deposit details in section E on the Practitioner Information form - AHC0912.
- When a new practitioner is joining an existing business arrangement (section F on the AHC0912 form), the direct deposit provision already established for that business arrangement applies.
- When a registered practitioner is setting up a new business arrangement, they provide their direct deposit information for that new business arrangement by completing a Business Arrangement Request form - AHC0913.
- A registered practitioner who wishes to change their direct deposit information for an existing business arrangement must complete an Electronic Funds Transfer 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. To ensure readability, please clearly re-print these numbers, in black ink, above or below the pre-printed bank numbers. Information that is not legible may delay your payment.

1.5.4 The business arrangement and the submitter

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

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

- If you are joining an existing business arrangement, the submitter for that business arrangement will handle your claims.
- If you are setting up your own practice or clinic, you will need to obtain the services of an accredited submitter; or you can apply to become your own submitter.
 - If you are using an existing accredited submitter, you and your submitter will need to complete a Submitter/Client Relationship for Electronic Claim Submission form - AHC2096.
 - If you want to be your own submitter, you will need to complete an Application for Submitter Role - AHC2095.

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, dial 310-0000 then enter 780-644-7643 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, be sure Alberta Health and Wellness has received and processed all claims, including resubmissions, from the old submitter **before** you change to the new submitter.

1.6 Registering your facility

If you are setting up a brand new office, clinic or other facility, you must register the facility with Alberta Health and Wellness. Facility registration identifies the physical location (e.g., practitioner's office) where health services are routinely performed, as well as any functional centre(s) within the facility (examination room, approved non-hospital surgical suite, etc.).

Each facility is assigned a five-digit or six-digit facility number. This number is address-linked (i.e., not transferable to another physical location) and remains the same no matter how many practitioners work out of the location. Claims for services provided in the facility must include the facility number.

A facility may also have a three-digit number for insured services contracted with Alberta Health Services. To ensure the correct facility number is used on a claim for insured services, the practitioner must check with the facility operator to determine if the service is contracted with Alberta Health Services or is a regular service. The following guidelines will help determine the correct facility number for the claim.

If the insured service is...

enter this facility number on the claim...

1. part of a facility/Alberta Health Services contract:

✓ three-digit facility number

2. not part of a facility/Alberta Health Services contract:

✓ five-digit or six-digit facility number

1.7 Changing the location of your practice

If you change the physical location of your practice, you will also have to change your facility number. Facility numbers cannot be transferred when you change locations. Claims for insured services you provide at the new location must include the facility number of the new location.

- If your new location already has a facility number, you should advise Alberta Health and Wellness of the new practice location. If you are changing the facility name and/or governing stakeholder for the new location, complete a Facility Registration form - AHC0910A. You should also advise Alberta Health and Wellness if any other information is changing (e.g., business arrangement, telephone number).
- If your new location does not have a facility number, complete a Facility Registration form - AHC0910A. This form can also be used to end a facility site if no one is practising there any longer.

1.8 Changing your business mailing address

If your business mailing address is changing, there are three ways you can notify Alberta Health and Wellness:

- Fax a letter to 780-422-3552.
- Call the Professional and Facility Management unit in Edmonton at 780-422-1522, or toll-free 310-0000 then 780-422-1522 when prompted.
- Send an email to health.practitionerinquiries@gov.ab.ca.

Remember to provide your new address and your PRAC ID. If you are part of a professional corporation and the organization's business mailing address is changing, you also need to provide the organization's identifier number in your notification.

1.9 Buying an existing practice or clinic

If you are buying an existing practice or clinic, you will probably want to change all records that refer to the previous owner. You will need to complete these forms:

Organization Information: AHC0911	To identify the name of the clinic or professional corporation.
Business Arrangement Request: AHC0913	To set up a new business arrangement.
Business Arrangement/Service Provider Relationship: AHC0914	If other practitioners will also be submitting claims under your new business arrangement.
Facility Registration: AHC0910A	If you need to change the facility or governing stakeholder name.

If you need more information about Alberta Health and Wellness requirements when purchasing an existing practice, call the Professional and Facility Management unit in Edmonton at 780-422-1522, or toll-free 310-0000 and then 780-422-1522 when prompted.

1.10 Form samples

Following are samples of the various forms a practitioner may require, as discussed in this section. 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/AHCIP/forms-claims.html.



Facility Registration Delivery Site Registry

Alberta Health and Wellness
 Professional and Facility Management Unit
 PO Box 1360 Station Main
 Edmonton AB T6J 2N3

For AHW office use only

DSR#

DID#

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

Section A - Add/Change/End a Facility

Add a new facility

Effective date

Year	Month	Day

Change to an existing facility

Effective date

Year	Month	Day

Facility number

--

End an existing facility

Effective date

Year	Month	Day

Facility number

--

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

Delivery site type: Practitioner office

Section B - Facility Identification

Facility common name

Organization name (identifies the practitioner, clinic or professional corporation operating the facility)

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

Clinical lab*

Other diagnostic lab*

(Practitioner's office)

Diagnostic imaging*

Electrodiagnosis*

Non-hospital surgical suite*

Radiology oncology*

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

Signature

Name and position/title

Date

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

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

AHC0910A (2010/04)



Practitioner Information

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

For AHW office use only

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

Section A - New practitioner registration

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

Section B - Identification

Have you ever been registered with Alberta Health and Wellness? Yes No

Provide your Personal Health Number

OR

Provide your out-of-province health number (if applicable)

Last name	First name	Middle name
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth
	Year Month Day

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

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

Section C - Organization information

Organization name			
Business mailing address			
<input type="checkbox"/> Same as business mailing address in Section B or			
City/Town		Province	
Country		Postal code	
Phone number		Fax number	

AHC0912 (2010/04)

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 and Wellness. It is collected under the authority of sections 20(b) and 27 of the *Health Information Act*. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have questions regarding the collection of this information, please contact the Professional and Facility Management Unit at the address 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 and Wellness 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 and Wellness to establish the arrangement for the payment of health services provided. All practitioners registered with Alberta Health and Wellness 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 and Wellness.
- 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 and Wellness 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.



Electronic Funds Transfer Request

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

For AHW office use only

This form authorizes Alberta Health and Wellness to directly deposit funds into the account described. Attach either a void cheque or a letter from your financial institution for account information confirmation. A contract holder (*see section B*) is a person, organization or professional corporation entering into a business arrangement with Alberta Health and Wellness.

Section A - Identification, type and date of change

Banking information to be applied to business arrangement(s)

Specify the identifier to be used for this banking information

Practitioner identifier

or

Professional corporation or clinic ULI

Name

Effective Year Month Day

Direct deposit to

or

Chequing – attach a void cheque

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

Branch transit number

Bank number

Account number

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

Practitioner's signature

Phone number

BA contract holder signature

Phone number

BA contract holder name and position/title

Date

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

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

AHC1143 (2010/04)

Government of Alberta

Application for Submitter Role

Alberta Health and Wellness
Professional and Facility Management Unit

- **Required fields are bolded.**
- Please print all information.
- For information on completing this form, see reverse.

Section A - Submitter Role Application

Please check (✓) one of the following:			Date		
<input type="checkbox"/> Create <input type="checkbox"/> Amend (<u>underline amendments</u>) <input type="checkbox"/> Delete			Year	Month	Day
Name (practitioner or company)			Practitioner ID* (if already assigned)		
Business phone number	Business fax number	Business email			
Mailing address			Physical address		
City/Town Province Postal code			City/Town Province Postal code		

Section B - Technical Software Contact Information

Name		
Business phone number	Business fax number	Business email

* The Practitioner ID will be used to assign a Submitter Role.

Section C - Submitter Agreement

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

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

Last name	First name	Middle name
Signature	Business phone number	Date
X		Year Month Day

Section D - Accreditation (Alberta Health and Wellness use)

Authorized by (name and signature)	Submitter prefix code	Date
		Year Month Day

Note: To obtain access to H-Link, the following forms must also be completed:

- AHC2123 Facility Site Registration
- AHC2214 Access Administrator Application Agreement and Authorization
- AHC2215 External User ID Application Access Request

Mail completed forms to: Alberta Health and Wellness **or** **Fax completed forms to:** 780-422-7248
 H-Link Administration Attention: H-Link Administrator
 PO Box 1360, Stn Main
 Edmonton AB T5J 2N3

The information requested on this application is being collected by Alberta Health and Wellness pursuant to section 20(b) of the *Health Information Act* and section 33 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 above.

AHC2095 (2010/04)

Instructions for Completion of this Form

The following provides instructions for the completion of the Application for Submitter Role form. For effective processing by Alberta Health and Wellness, please ensure accurate completion of all required forms.

Step 1: Complete Sections A through C

Section A: (For completion by the practitioner or clinic requiring a Submitter Role.)

What is a Submitter Role?

It is the accreditation required to electronically submit and/or retrieve files using H-Link.

What information is required for the Name?

For practitioners it is the professional name and for clinics it is the legal name of the company.

What is the Practitioner ID?

It is the identifier assigned by Alberta Health and Wellness to the practitioner or clinic requesting a Submitter Role. This includes Practitioner Identifiers (PRACID) or Organization Stakeholder Identifiers. In order to protect an individual's health information, Alberta Health and Wellness suggests you do not use an individual's Personal Health Number on these forms.

Section B:

Who is the Technical Software Contact?

It is the individual in your organization responsible for providing technical support and who Alberta Health and Wellness may contact with respect to technical inquiries.

Section C:

Who signs the Submitter Agreement?

It is the practitioner or representative within a company duly authorized (i.e. practitioner, owner, administrator, etc.) to sign legal documents.

Section D:

This is reserved for Alberta Health and Wellness.

Step 2: Complete additional forms

In addition to the Application for Submitter Role, the following security access forms are required to obtain access to H-Link:

AHC2123 Facility Site Registration

AHC2214 Access Administrator Application Agreement and Authorization

AHC2215 External User ID Application Access Request (if not already assigned)

Please complete and submit **all** required forms to Alberta Health and Wellness for processing.

Step 3: Role of Alberta Health and Wellness

Alberta Health and Wellness will review and authorize the Application for Submitter Role and register the Submitter Role by assigning a submitter prefix and Unique Lifetime Identifier.

Step 4: Receipt of submitter package

Once all forms are processed and approved, Alberta Health and Wellness will courier a submitter package containing a fob and an information letter to the physical address provided in section A.

**Government
 of Alberta**

**Submitter/Client Relationship for
 Electronic Claim Submission**

Alberta Health and Wellness
 Professional and Facility Management Unit
 PO Box 1380 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) _____

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

Submitter

Name _____	Submitter prefix code _____
ULI number _____	Proposed submission date _____

Contract holder certification and agreement

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

Signature(s) _____

 Name(s) _____

 Date _____

Submitter certification and agreement

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

Signature(s) _____

 Name(s) _____

 Date _____

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

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

AHC2096 (2010/04)

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 the Alberta Health Care Insurance Plan (AHCIP). Every resident who registers 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 and Wellness 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 – they must 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.

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. To assist you with this, Alberta Health and Wellness provides a 24-hour interactive telephone inquiry service. (See **2.3 Using the interactive voice response (IVR) system.**)

2.2 Patients who are eligible

To confirm a **new** patient's identity, we strongly recommend you:

- View their personal health care card.
- Request picture ID, such as a driver's licence.
- Verify the patient's address. If there has been an address change, please ask the patient to call Alberta Health and Wellness to advise of the change.



Note: Our automated telephone system allows residents to change information such as address. In Edmonton, they can call 780-427-1432. Outside Edmonton, residents can call toll-free 310-0000 then 780-427-1432 when prompted.

If a patient presents an Alberta personal health card but provides an out-of-province address, call the 24-hour interactive telephone inquiry service (see section **2.3**) to confirm if the patient has Alberta eligibility. If the patient is eligible, submit a claim to the AHCIP.

2.3 Using the interactive voice response (IVR) system

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

Using the IVR system before a claim is submitted will assist you by reducing the time and effort spent to resolve claims that are refused due to problems with a PHN. 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 (not in effect) 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.**

The IVR system cannot be used to determine whether a patient is eligible for benefits that are subject to specific limits, such as podiatry and optometric visits. This type of confirmation can only be obtained by calling the Health Care Insurance Plan Administration Branch in Edmonton at 780-422-1600 (toll-free 310-0000 then enter 780-422-1600) and arranging for a "limits" letter to be sent to the patient.

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.)
- Those who have chosen to formally opt out of the AHCIP.
- Those who have not yet registered with Alberta Health and Wellness.
- Those who present a health care card that is not active (confirmed by IVR - see section 2.3).
- RCMP members, 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: In November 2009 Alberta Health and Wellness began a two-year pilot project to enable practitioners to submit claims for services provided to Alberta RCMP members directly to Alberta Health and Wellness for payment consideration. See Bulletin Gen 74 dated October 29, 2009, for more information.

Dependants of non-eligible RCMP members, Canadian Forces personnel and federal penitentiary inmates who reside in Alberta must register with the AHCIP.

2.5 The patient 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.

- 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. to 4:30 p.m. except on government holidays and is for the **exclusive** use of practitioner offices. Please do not give this number to the public, as it will affect our ability to provide prompt and efficient service to practitioner offices.



Note: A current Alberta address by itself does not mean a resident is covered by the AHCIP. Residents who have moved to Alberta may be covered by their previous home province/territory plan for up to three months. Practitioners may wish to 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 complete and return a Declaration of Election to Opt Out form - AHC0207 to Alberta Health and Wellness. 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.



Note: To check the status of a PHN at any time, call 780-422-6257 in Edmonton or toll-free 1-888-422-6257. (See **2.3 Using the interactive voice response (IVR) system.**)

2.7 Your options for patients who do not have active AHCIP coverage

Bill the patient directly and, if applicable, either:

- Submit an electronic pay-to-patient claim to the AHCIP on the patient's behalf (your accredited submitter can explain this process). This will enable eligible patients to be reimbursed by the AHCIP up to the maximum amount payable for the service.

or

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

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. In Edmonton, call 780-415-2288. Outside Edmonton, call toll-free 310-0000 and then enter 780-415-2288 when prompted. (See **2.5 The patient 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. You can also use this fax number to order a supply of the AHC0406 form.
- Arrange to bill the patient directly and, if applicable, submit an electronic pay-to-patient claim. Your accredited submitter can explain this process.

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 and Wellness 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 the caller wishes to remain anonymous.

3.0 Preparing a claim for submission

If you/your billing staff prepare computer-generated claim submissions, it is essential to know your submitter's information reporting requirements and how to use their billing software to correctly create new claims 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 **3.4 Claim segments**.)

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



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

3.1 Claim basics

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

WHO was involved:

Enter:

- The personal health number of the patient.
- The practitioner identification number (PRAC ID) of the practitioner who provided the service.
- If applicable, the PRAC ID of the referring practitioner.

WHAT service was performed:

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

WHERE it occurred:

Enter the facility number.

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

WHEN it occurred:

Enter the date of service.

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

WHY the procedure was done:

When applicable, from the Alberta Health and Wellness Diagnostic Code List, enter the code(s) for the disease, condition or purpose related to the service you are claiming.

3.2 Claim submission and processing timelines

To be considered for payment, claims must be received at Alberta Health and Wellness within 180 days from the date on which the health service was provided. 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. (See **5.3 Outdated claims**.)

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

Exceptions to this payment schedule are:

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

Practitioner offices and submitters are notified regarding exceptions to the payment schedule via Alberta Health and Wellness Bulletins 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 and Wellness.

3.3 Action codes

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

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

Action code

When to use

A (add):

To submit a claim for the first time or to resubmit a claim that was refused (result code RFSE) on the Statement of Assessment. (See **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 **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
 - practitioner's PRAC ID
 - business arrangement number

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

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

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

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

- Use the same claim number from the Statement of Assessment.
- You do not need a base claim segment or person data segment.
- You must **delete** the original claim if you want to change any of these details:
 - patient's personal health number
 - practitioner's PRAC ID
 - business arrangement number

Then submit a new claim (action code A) with the correct information and a new claim number.

- Pay-to-patient claims **cannot** be deleted.

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

3.4.1 In-Province Provider Base Claim Segment – CIB1

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

Claim Type:

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

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

PRAC ID:

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

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

Skill Code:

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

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

Service Recipient PHN:

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

- If the claim is for a newborn whose PHN is unknown, leave this field blank and provide information in the person data segment of the claim. (See **3.4.2 Claim Person Data Segment**.)

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

Health Service Code:

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

- **Reminder to dentists and podiatrists:** Procedures claimed under section 99.09 (Procedures not elsewhere classified) require supporting text/documentation.
- 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, enter the date of the first day of consecutive hospital visit days. In the Calls field, enter the number of consecutive days of visits, to a maximum of 99 days.

For a patient in hospital longer than 99 days, start a new claim for the additional days, beginning at call one (1). Enter the original admission date in the Hospital Admission Date field.

- Except for hospital in-patient services, claims may not be submitted more than 180 days from the date of service.

Encounter Number:

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

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

Diagnostic Code:

Using the Alberta Health and Wellness Diagnostic Code List, 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.
- **Important note:** Diagnostic codes are required for podiatrists, dentists, and where applicable, optometrists.

- Calls:** Applies to dentists and podiatrists. Enter up to three digits to identify the number of calls for the health service code you are claiming, or the number of units for time-based services you provided.
- Where applicable, the Price List in the Schedule of Benefits identifies the maximum calls allowed for each health service code, or the number of units for time-based services.
 - If the number of services you provided exceeds the maximum specified for that health service code, submit your claim with the actual number of calls plus supporting text or documentation for the claim to be considered for payment. Claims without this information will be automatically reduced to the maximum calls specified in the Price List.
 - Hospital visits are restricted to **two digits**; i.e., to a maximum of 99 calls per claim. (See **Service Start Date** field.)
- Explicit Fee Modifier:** Modifiers are used in conjunction with the health service code to determine the amount payable. (See **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., practitioner's office, hospital, etc.).
- Leave blank if the service was performed in a location that is not a registered facility. (See **Location Code** field.)
- Functional Centre:** Complete this field only if the service was performed at a registered facility that has functional centre codes. Example: an examination room 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 (see **Introduction**) for detailed information about facility numbers and functional centre codes for Alberta's publicly funded facilities.
- Location Code:** If the service was performed in a location that is not a registered facility, enter either HOME (for the patient's home) or OTHR (other), as applicable.
- Business Arrangement:** Enter the business arrangement number under which the practitioner is making the claim. (See **1.0 AHCIP Basics for the Practitioner**.)

- Pay-to Code:** Enter the applicable code to identify the person or organization that is to receive the claim payment:
- BAPY** (Business arrangement payee) – Used most often, this code is used to pay the practitioner, clinic or professional corporation as defined in the business arrangement.
 - CONT** (Contract holder) – Pay the AHCIP registrant (head of the family).
 - RECP** (Service recipient) – Pay the patient.
 - PRVD** (Service provider) – Pay the practitioner. This code is not often used; BAPY is used for direct provider payment.
 - OTHR** (Other) – Someone other than the above. (See **Pay-to PHN** field.)
- A patient under age 14 cannot be the payee. If you want the patient's parent to be paid, enter CONT. For a guardian or other responsible party to be paid, enter OTHR. (See **Pay-to-PHN** field.)
- Pay-to PHN:** If you enter OTHR in the Pay-to Code field and you know the other person's personal health number, enter it here.
- If you do not know the PHN, fill out a person data segment for the payee.
- Referral PRAC ID:** If the service was provided because of a referral, enter the referring provider's PRAC ID.
- **Do not** enter a professional corporation identifier number in this field or the claim will be refused.
- Out-of-Province Referral Indicator:** This field is required **only** for Alberta patients who are referred by an out-of-province provider.
- Enter Y if a provider outside Alberta referred the patient for service. Complete a person data segment for the out-of-province provider.
- Chart Number:** This field is reserved for practitioner use. You can enter up to 14 alphanumeric characters as a source reference or other type of file identifier.
- Claimed Amount:** If the claim is “by assessment” or for an unlisted procedure, enter the fee requested. You will also need to provide supporting text or documentation.
- Claimed amount is not required for other health service codes unless you are requesting a lower fee than what is listed in the Schedule.

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

Intercept Reason: This field is currently not used.

Good Faith Indicator: Enter Y if submitting under the good faith policy. (See **5.1 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.

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

- Send supporting documentation on paper only if it contains diagrams or an operative report and if including a text segment on the claim would be insufficient.
- Send the supporting documentation at the same time the claim is submitted. Be sure it makes reference to the applicable claim number.

Hospital Admission Date: Applies to dentists and podiatrists. This field is used when claiming for hospital visits.

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

3.4.2 Claim Person Data Segment – CPD1

This segment must be completed for:

- A patient (RECP) who does not have a PHN or does not know their PHN (i.e., good faith claim – see **5.1 Alberta's good faith policy**.)
- A newborn patient without a PHN. (See **5.2 Newborn claims – Alberta residents**.)
- An “other” payee (OTHR); i.e., when someone other than the patient or AHCIP registrant (head of the family) has paid the claim and now wants to be reimbursed.

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

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

3.4.3 Claim Supporting Text Segment – CST1

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

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

3.4.4 Supporting Text Cross Reference Segment – CTX1

This segment applies when the same supporting text is used for more than one claim. Up to 14 other claims can be cross-referenced to one claim that contains the relevant supporting text.

Check with your submitter regarding the data requirements of this segment.

3.5 Mandatory claim fields and segments

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

If the claim involves ...	then you must complete this field/segment ...
1. a first-time claim for a newborn:	<ul style="list-style-type: none">✓ newborn code✓ person data segment (including parent/guardian PHN)
2. good faith:	<ul style="list-style-type: none">✓ good faith indicator (enter Y)✓ person data segment
3. pay-to code OTHR:	<ul style="list-style-type: none">✓ pay-to PHN field or person data segment
4. out-of-province referral:	<ul style="list-style-type: none">✓ out-of-province referral indicator✓ person data segment

3.6 Modifier codes

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

All current modifier codes and their explanations are listed in the Modifier Definitions section in the Schedule of Benefits. The Price List section in the Schedule lists the specific modifiers that apply to each health service code. (See **7.5 A sample page from the Price List.**)

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

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

- **Role** – Identifies the practitioner's function at the time service was provided; e.g., surgical assistant.

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

- **Lesser value procedure** – Indicates that this procedure should be processed at a reduced rate.

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

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

3.7 Submitting claims for unlisted procedures

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

- First, you need to determine if the service is insured under the Alberta Health Care Insurance Plan (AHCIP).
- If the service is insured, thoroughly 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 elsewhere in the Schedule, submit your claim using the appropriate code from the 99.09 section of the Schedule.
- When preparing a claim for an unlisted procedure, you will need to determine an equivalent or comparable service listed in the Schedule in terms of time, complexity and intensity. You will need to provide supporting information, such as an operative report or descriptive text. Be sure to include equivalencies, the service description, and the amount claimed in your supporting information.

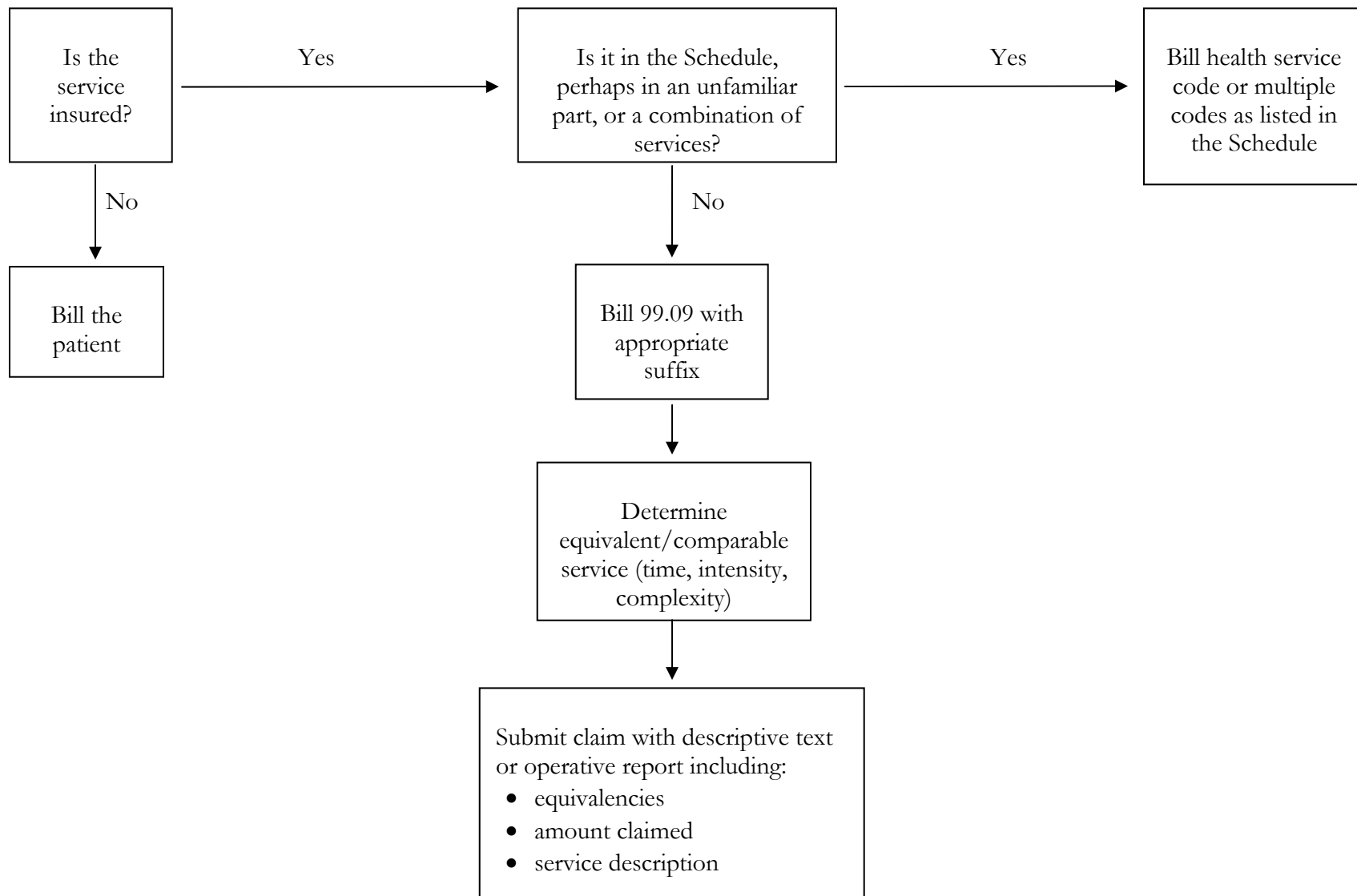
Alberta Health and Wellness assesses claims for unlisted services by comparing the service provided and the fee claimed with similar or comparable services listed in the Schedule. The assessment will be based on information concerning the time, complexity and intensity of the service, as provided on your claim.



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

Please refer to the next page for a flow chart depicting the process of submitting a claim for an unlisted procedure.

Flow chart – Submitting a claim for an unlisted procedure



4.0 Out-of-province patients

4.1 Two ways a practitioner can bill


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

1. Complete an Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. (See section 4.3 for a form sample.) Submit the claim to the patient's home province or territory for payment consideration. (See 4.2 **Province/territory contact information and claim submission limits**.)
2. Bill the patient directly. Provide them with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. The patient may submit the claim to their home province health plan for reimbursement. A copy may be retained in the practitioner's office as a record of payment.



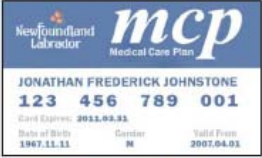



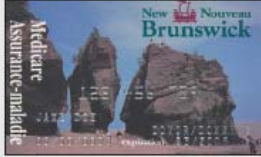





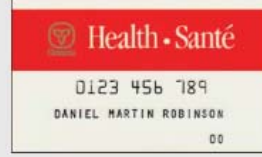



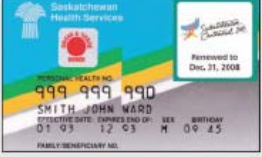
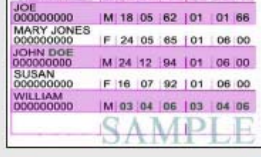





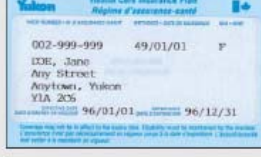
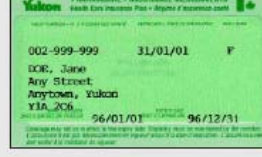


Note: The Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 is available on our website at www.health.alberta.ca/AHCIP/forms-claims.html.

Part A and B on this form are completed by the patient/parent. Part C is completed by the practitioner. Please ensure that all applicable information about the service has been provided and that you have signed the form. Also, be sure to indicate who is to be paid for the service.



Health Canada
Santé Canada

Valid Insured Health Service Plan Cards
Cartes valides des régimes de soins de santé assurés

 <p>NEWFOUNDLAND AND LABRADOR mcp Medical Care Plan JONATHAN FREDERICK JOHNSTONE 123 456 789 001 Card Expires: 2011.03.31 Date of Birth: 1967.11.11 Gender: M Valid From: 2007.04.01</p>	 <p>NEWFOUNDLAND AND LABRADOR mcp Medical Care Plan O'HALLERAN PATRICK MICHAEL FRANCIS 000 000 000 000 Card Expires: 2010/12/31 Birth Date: 1951/11/23 Gender: M Valid From: 2006/01/01</p>	 <p>Health JOHN A. SWALE 1400/00/00</p>
 <p>Health Birth: 1970-08-11 Effective: 2008-01-01 Expiry: 2010-01-01</p>	 <p>Medicare Assurance-maladie LOMBE SMITH 11120000 • 01/01/2008</p>	 <p>Medicare Assurance-maladie LOMBE SMITH 11120000 • 01/01/2008</p>
 <p>VAP 0000 0000 PHILIPPE VAILLANCOURT 000000 M</p>	 <p>VAP 0000 0000 PHILIPPE VAILLANCOURT 000000 M</p>	 <p>VAP 0000 0000 PHILIPPE VAILLANCOURT 000000 M</p>
 <p>Health • Santé ANITA JEAN WALKER 5504-486-674-YM 1981-12-15</p>	 <p>Health • Santé Anne Nicole Gilbert 3821 • 694 • 372 • AM 1966 • 12 • 05</p>	 <p>Health • Santé 0123 456 789 DANIEL MARTIN ROBINSON 00</p>
 <p>Health • Santé 65 0123 456 789 ROBINSON, DANIEL MARTIN 08992551</p>	 <p>REGISTRATION CARD JOE SMITH 300 CARLTON STREET WINNIPEG MB R5B 3M9 000000 VALID ONLY IF RESIDENT OF MANITOBA</p>	 <p>REGISTRATION CERTIFICATE JOHN DOE 599 EMPRESS ST. WINNIPEG, MB R3C 2T6 223456</p>
 <p>999 999 990 SMITH JOHN WARD 01/03/12 C3 M 09/25</p>	 <p>MANITOBA SAMPLE JOE SMITH M 18 05 62 01 01 86 MARY JONES F 24 05 65 01 06 00 SUSAN M 24 12 94 01 06 00 JOHN DOE F 16 07 92 01 06 00 WILLIAM M 03 04 06 03 04 06</p>	 <p>223456 JOHN 111 111 111 M 04/62 01/04/62 222 222 222 F 09/61 15/09/61 333 333 333 M 12/84 16/12/84</p>
 <p>999 999 990 SMITH JOHN WARD 02/2002 02/2008 M 04/1945</p>	 <p>Alberta Personal Health Card Please protect this card Personal Health Number 12345-0000 John Doe 0000/00/00</p>	 <p>CareCard PERSONAL HEALTH NO. 9121 428 823 03/02/11</p>
 <p>CareCard PERSONAL HEALTH NO. 9121 428 823 03/02/11</p>	 <p>Yukon Health Care Insurance Plan 002-999-999 49/01/01 P Yukon 96/01/01 96/12/31</p>	 <p>Yukon PHARMICARE • ASSURANCE-MÉDICAMENTS 002-999-999 31/01/01 F Yukon 96/01/01 96/12/31</p>
 <p>NWT Health Care Plan SMITH, JANE MARIE N5739906 EXP 03/31/2010</p>	 <p>123456789 Joe Inuk 21/05/1950 Expiry 31/03/2011</p>	

Interprovincial Health Insurance Agreements Coordinating Committee - February 2008
Comité de coordination des ententes interprovinciales en assurance-santé - Février 2008

NCN1353 (2008/03)



4.2 Province/territory contact information and claim submission limits

British Columbia

Medical Services Plan
1515 Blanshard Street
Box 9035
Station Provincial Government
Victoria BC V8W 9E2
Phone: 1-800-663-7100
Fax: 250-405-3592

Time limit: 3 months

New Brunswick

Department of Health and Wellness
PO Box 5100
Fredericton NB E3B 5G8
Phone: 506-453-2283
Fax: 506-453-2726

Time limit: 6 months

Northwest Territories

Department of Health and Social Services
Health Services Administration
Second floor, IDC Building
Bag #9
Inuvik NT X0E 0T0
Phone: 1-800-661-0830
Fax: 867-777-3197

Time limit: 6 months

Nunavut

Health Insurance Programs
Department of Health and Social Services
Bag 003
Rankin Inlet NU X0C 0G0
Phone: 1-800-661-0833
Fax: 867-645-8092

Time limit: 1 year

Manitoba

Manitoba Health
300 Carlton Street
Winnipeg MB R3B 3M9
Phone: 204-786-7101
Fax: 204-783-2171

Time limit: 6 months

Newfoundland and Labrador

Newfoundland and Labrador Medical Care Plan
PO Box 5000
Grand Falls - Windsor NL A2A 2Y4
Phone: 709-292-4000
Fax: 709-292-4053

Time limit: 6 months

Nova Scotia

Medical Services Insurance
PO Box 500
Halifax NS B3J 2S1
Phone: 902-468-9700
Fax: 902-490-2275

Time limit: 6 months

Ontario

Ministry of Health and Long-Term Care
Support Services Manager
75 Albert Street
Ottawa ON K1P 5Y9
Phone: 613-783-4401
Fax: 613-237-3246

Time limit: 6 months

Prince Edward Island

Department of Health and Social Services
Medicare Division
PO Box 3000
Montague PE C0A 1R0
Phone: 902-838-0900
Fax: 902-838-0940

Time limit: 6 months

Saskatchewan

Saskatchewan Health
3475 Albert Street
Regina SK S4S 6X6
Phone: 306-787-3475
Fax: 306-787-3761

Time limit: 6 months

Québec

Services médicaux hors du Québec
Régie de l'assurance-maladie du Québec
Case postale 6600
Québec QC G1K 7T3
Phone: 1-800-463-4776
Fax: 418-646-9251

Time limit: 2 years

Yukon

Department of Health and Social Services
Health Services Branch
PO Box 2703
Whitehorse YT Y1A 2C6
Phone: 867-667-5209
Fax: 867-393-6486

Time limit: 6 months

4.3 A sample out-of-province claim form – AHC 0693

OUT-OF-PROVINCE CLAIM FOR PHYSICIAN/ PRACTITIONER SERVICES				<div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> SPACE PROVIDED FOR ADMINISTRATIVE PURPOSES																														
A To be completed by Patient or Parent / Guardian of Patient (please type or print clearly)																																		
PATIENT'S SURNAME ON HEALTH CARD			FIRST NAME		INITIALS	HEALTH CARE NUMBER																												
PERMANENT MAILING ADDRESS					DATE OF EXPIRY																													
CITY		PROVINCE/TERRITORY			POSTAL CODE																													
BIRTHDATE YEAR MONTH DAY		SEX <input type="checkbox"/> M <input type="checkbox"/> F	NAME OF PARENT / GUARDIAN			RELATIONSHIP TO PATIENT																												
DATE OF DEPARTURE FROM HOME YEAR MONTH DAY		PLACE WHERE TREATED (PROVINCE, TERRITORY)			DATE OF ARRIVAL YEAR MONTH DAY	IS THIS A PERMANENT MOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, SPECIFY DATE OF RETURN HOME YEAR MONTH DAY																											
GIVE REASON FOR ABSENCE FROM HOME: <input type="checkbox"/> VACATION <input type="checkbox"/> STUDY		NAME OF INSTITUTION			PLEASE SPECIFY <input type="checkbox"/> BUSINESS <input type="checkbox"/> OTHER																													
B Declaration of Patient or Parent / Guardian of Patient																																		
I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the Canada Evidence Act, that the information given above is correct and that I am a beneficiary of the Medical Care Plan in the province/territory of _____.																																		
I request that payment be made: directly to the physician/practitioner <input type="checkbox"/> to patient/contract holder <input type="checkbox"/>																																		
SIGNATURE OF PATIENT (if other than patient, state relationship to patient)				DATE	TELEPHONE NO. (Home) AREA CODE ()	TELEPHONE NO. (Work) AREA CODE ()	EXT.																											
C To be completed by Physician / Practitioner (please type or print clearly)																																		
PHYSICIAN'S/PRACTITIONER'S NAME AND INITIALS				SPECIALTY <input type="checkbox"/> CERTIFIED <input type="checkbox"/> NON-CERTIFIED																														
ADDRESS				CHECK HERE IF: <input type="checkbox"/> ANAESTHETIST <input type="checkbox"/> SURGICAL ASSISTANT <input type="checkbox"/> PSYCHIATRIST		PROVIDE DURATION OF SERVICE HRS MINS																												
POSTAL CODE				NAME OF REFERRING PHYSICIAN/PRACTITIONER (IF APPLICABLE)		SPECIALTY																												
IF HOSPITAL SERVICES, PLEASE PROVIDE: NAME OF HOSPITAL ADDRESS				SERVICES PROVIDED <input type="checkbox"/> OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL OUT-PATIENT <input type="checkbox"/> HOSPITAL IN-PATIENT		ADMISSION DATE YEAR MONTH DAY																												
						DISCHARGE DATE YEAR MONTH DAY																												
IF CLAIMING IN-PATIENT CARE, PLEASE INDICATE SERVICE DATES																																		
SERVICE DATE(S)	YEAR	MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
PROCEDURE/TREATMENT			FEE CODE	FEE	DATE OF SERVICE YEAR MONTH DAY		TIME	FOR OFFICE USE ONLY																										
DIAGNOSIS AND OTHER REMARKS																																		
CLAIM INVOLVES: <input type="checkbox"/> WORKERS' COMPENSATION <input type="checkbox"/> PENSIONABLE DISABILITY <input type="checkbox"/> AUTOMOBILE ACCIDENT <input type="checkbox"/> OTHER THIRD PARTY								<input type="checkbox"/> PAY PHYSICIAN/PRACTITIONER I accept the patient's plan payment as payment in full		<input type="checkbox"/> PAY PATIENT		<input type="checkbox"/> OTHER (SPECIFY) _____				PHYSICIAN'S/PRACTITIONER'S SIGNATURE						DATE		LANGUAGE OF CORRESPONDENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH										
AHC0693 (2005/01)																																		

5.0 Special claim situations

5.1 Alberta's good faith policy

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

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

1. The patient is a permanent Alberta resident and eligible for AHCIP coverage, and
2. The patient is who they say they are. We suggest asking patients to present picture identification that also displays their address, such as a driver's licence.

A resident of Alberta is defined in legislation 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: RCMP members, 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, we suggest you ask this question: **Do you have an Alberta Personal Health Card or Alberta personal health number?**

- If the patient answers **yes** and they present a card or number, your office may wish to confirm if coverage is active/the number is valid by calling our IVR number at 780-422-6257 in Edmonton (toll-free 1-888-422-6257). (See **2.3 Using the interactive voice response (IVR) system.**) If the IVR system confirms that coverage is not active, you can ask the patient (or parent/guardian) to pay you directly for any service they receive.
- If the patient answers **yes** but they do not have their card or number to present, you can call the Registration Research unit in Edmonton at 780-415-2288 (toll-free via 310-0000). Staff in this unit will use the patient information you provide to search for an active personal health number and provide it if available, or advise you if there is no active coverage for a particular date of service.



Note: This inquiry line is for practitioner offices only. Please do not give the Registration Research number out to patients.

- If the patient states that they do not have an Alberta Personal Health Card or Alberta personal health number, then ask them:
 - **Do you have a health care card and active coverage with another province or territory in Canada?**
 - **Do you have coverage with another insurer?**
 - **Are you a resident of another country?**

If the patient answers **yes** to any of these questions, a good faith claim **cannot be submitted**. As applicable, bill the other insurer or bill the patient directly and provide them with a claim to submit to their insurer. (See **4.1 Two ways a practitioner can bill**.)

If, after questioning the patient who does not have an Alberta Personal Health Card or number, you are confident he/she is an Alberta resident who has lived in the province for three months or more and is eligible for AHCIP coverage, a claim can be submitted “in good faith.”

To qualify for processing under the good faith policy, good faith claims must be received at Alberta Health and Wellness **within 30 days from the date of service**. If all criteria for a good faith submission are met, the initial claim for the patient may qualify for good faith processing. Subsequent services provided to the same patient by another practitioner using the same business arrangement number must be submitted to Alberta Health and Wellness 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 **3.4.1 In-Province Provider Base Claim Segment**.)
- Attach a person data segment and enter the personal information collected from the patient, including their name and permanent Alberta address. (See **3.4.2 Claim person data segment**.)

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

Good faith payments made for ineligible patients will not be recovered from the practitioner; however, Alberta Health and Wellness reserves the right to recover payment from an ineligible patient.

5.2 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 – no dashes, abbreviations or punctuation, or the claim will be refused



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.

5.3 Outdated claims

Alberta Health and Wellness regularly receives requests from practitioners for special consideration regarding payment of outdated claims. To help ensure they receive all payments they are entitled to for services provided, practitioners (and their staff) are expected to use sound business practices that support timely claim submission and reconciliation practices.

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

- A claim to the AHCIP is not payable if it is received at Alberta Health and Wellness 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.

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.

If you wish to submit an outdated claim for which you believe extenuating circumstances apply, you must first send a written request to the address below. Describe the extenuating circumstance and include the number of claims involved, the specific dates, and the dollar values.

Manager, Claims and Professional/Facility Management
Health Care Insurance Plan Administration Branch
Alberta Health and Wellness
P O Box 1360 Station Main
Edmonton AB T5J 2N3
Fax: 780-422-3552
E-mail: health.practitionerinquiries@gov.ab.ca

Your request will be considered and a written reply provided, including resubmission instructions, if applicable.

5.4 Workers' Compensation Board (WCB) claims

Claims for Alberta residents who are injured at work should be submitted directly to the Workers' Compensation Board – Alberta. The mailing address for claims and contact numbers for more information are:

Workers' Compensation Board – Alberta
9912 - 107 Street NW
PO Box 2415
Edmonton AB T5J 2S5
Phone: Edmonton 780-498-3999
Calgary 403-517-6000
Toll-free 1-866-922-9221
Fax: 780-498-7999 or 1-800-661-1993
Website: www.wcb.ab.ca

If the WCB denies the claim and the service is insured under the AHCIP, you may submit a claim to the AHCIP with text indicating the date of the WCB letter informing you that the claim was denied. The claim to the AHCIP must be submitted **within 90 days** of your receipt of the WCB letter.

A **non-resident** of Alberta who is working in Alberta and 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 the AHCIP as good faith claims. Doing so will create a lengthy administrative process for your office to correct this submission.

5.5 Prior approval for health care services provided outside Canada

The AHCIP provides **limited coverage** for insured medical, oral surgical and hospital services obtained outside Canada in an emergency situation. However, for Albertans who require out-of-country medical care that is not available in Alberta or elsewhere in Canada, the Out-of-Country Health Services Committee (OOCHSC) is in place to evaluate applications for funding for elective services on a prior approval basis.

The Oochsc consists of four Alberta physicians and one non-voting chair who is an employee of Alberta Health and Wellness. The physicians and the chair are appointed by the Minister of Alberta Health and Wellness.

Applications for Oochsc funding can be made **only** by an Alberta physician or dentist on behalf of an Alberta resident. Several conditions must be met for an application to be considered:

- Funding must be approved **before** the services are provided.
- The services must be medically required.
- The services must be unavailable in Alberta or elsewhere in Canada.
- The services must be insured medical, oral surgical, and/or hospital services.
- The services cannot be experimental or in the research stage (clinical trial).
- The patient must be an Alberta resident who is registered with the AHCIP and who has not opted out of the Plan.

More information about Oochsc requirements is available on the Alberta Health and Wellness website at www.health.alberta.ca/AHCIP/coverage-outside-claims.html#OOCHSC. Information about the request for funding process is available by calling the Out-of-Country Health Services Committee office in Edmonton at 780-415-8744, or toll-free by dialling 310-0000, then 780-415-8744 when prompted.

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

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



Note: Submitting a request for funding to the Oochsc **does not guarantee approval**. All out-of-country health services funding decisions are based on medical and clinical information considered by the Oochsc and current legislative requirements.

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 or dentist who submitted the application for the Alberta resident, or by the Alberta resident. After review, the Appeal Panel may confirm or vary the 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 the following address:

Chair, Out-of-Country Health Services Appeal Panel
Alberta Health and Wellness
PO Box 1360 Station Main
Edmonton AB T5J 2N3
FAX: 780-422-1958

6.0 Reviewing claim results

6.1 Tracking your claim

Most AHCIP claims pass through the automated claims processing system without question or delay. However, claims that involve complex procedures may require more time-consuming manual assessment. Following is a brief description of the claim process:

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

A held claim is assessed manually. Either it will be found valid and processed for payment, or it will be refused. In either case, it will appear on your Statement of Assessment with a final assessment result.

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.

6.2 Checking your Statement of Assessment

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

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

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

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

Reconciling each Statement of Assessment with your claim submission records should be done regularly.

- 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.
- You should keep all Statements of Assessment and Statements of Account until you have completed your reconciliations and will not require them in the future. Section 15(2) of the *Alberta Health Care Insurance Regulation* states that **billing information must be kept for six years.**
- You may receive a separate Statement of Assessment that reports the results of your pay-to-patient claims. This is **not** a statement showing claim payments to **you** or deductions from **you**. Rather, this type of statement is issued, when applicable, to advise you about claim payments to or deductions from **your patient.**

If you already receive a statement directly from your submitter and do not wish to receive the Alberta Health and Wellness paper version, you can have the Alberta Health and Wellness copy suppressed by calling 780-422-1522 in Edmonton, or toll-free 310-0000 then 780-422-1522 when prompted.

If you are missing a Statement of Assessment and cannot obtain the required information from your submitter, you can order a replacement copy from our office by calling 780-415-8731 in Edmonton, or toll-free 310-0000 then 780-415-8731 when prompted. The interactive system will ask for your business arrangement number and the issue date (normally a Friday) of the missing statement.



Note: Please wait a minimum of **15 business days** from the issue date of the missing statement before calling for a replacement copy. Requests made prior to 15 days will **not** be accepted by the telephone system.

6.3 A sample Statement of Assessment

E400RS1

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

STATEMENT DATE: 2009/04/24
PAGE: 1

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

STATEMENT OF ASSESSMENT

5
Reference Nbrs
146098100 876198100

Business Arrangement 9999-999 **2**
Expected Payment Date 2009/05/01 **3**

6
Sequence Nbr
01

10	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	Mod Code	Mod Code	Result Code	Exp Code	Exp Code	Registration Number	RC
7 Boodek, Andrew		8 1992-39000													
9 Banery, Marvin	39053 26D	11 72636-9000	ELA09BA00007930	2009/02/05	99.99A	0.00	21.54				APLY				
Lodger, Beatrice	39053 35D	72658-9000	ELA09BA00008045	2009/02/17	99.99A	0.00	48.28				APLY				
Chipmon, Steve	39053 39D	91450-9000	ELA09BA00008078	2009/02/05	99.99A	0.00	31.87				APLY				
Quastell, Loni	39053 21C	92730-9000	ELA09BA00008086	2009/02/12	99.99A	0.00	21.54				APLY				
22 Total Amount to be Paid							123.23								
23 Total Amount (RVRSL)							0.00								
7 Doggle, A.C.		8 6843-39000													
Parsill, Judy		23735-9000	ELA09BJ00008060	2009/03/26	99.99A	0.00	437.59	SAU			APLY				
Rutlatch, Craig		37735-9000	ELA09BJ00008045	2009/03/25	99.99A	0.00	78.24	SAU			APLY				
Owins, Ollie		92649-9000	ELA09BJ00018895	2009/03/01	99.99A	0.00	75.63	SAU			APLY				
Total Amount to be Paid							591.46								
Total Amount (RVRSL)							0.00								
24 Summary Total															
25 Provider Name						26 Assessed Amount									
Boodek, Andrew							123.23								
Doggle, A.C.							591.46								
27 Total Amount to be Paid							714.69								

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

6.4 Statement of Assessment description

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 and Wellness.
5. **Reference Numbers**
ID number assigned to the Statement of Assessment produced.
6. **Sequence Number**
Sequential number indicating how many statements have been produced to date for your business arrangement.
7. **Practitioner**
Name of the person who delivered health care services billed to the AHCIP.
8. **Practitioner Identification Number (PRAC ID)**
Unique number identifying the service provider.
9. **Service Recipient Name**
Patient's full name. If this field contains all asterisks (**) it means the processing system could not derive a surname from the information on the claim. Most common causes: the personal health number was invalid or was not provided, or the person data segment was insufficient.
10. **Chart Number**
Source reference number provided on the claim transaction by the practitioner.
11. **PHN**
Personal health number identifying each patient.
12. **Claim Number**
Number assigned to each claim by the submitter.
13. **Service Start Date**
Date the service was performed, started or received.
14. **Service Code**
Unique code identifying the health service provided.

15. **Claimed Amount**
Amount claimed for the service provided.
16. **Assessed Amount**
Amount paid after application of assessment rules and other criteria.
17. **Modifier Code**
Explicit modifier code(s) affecting payment of a health service code.
18. **Result Code**
Code identifying whether a claim is being applied, held or refused.
19. **Explanatory Code**
Code explaining the reason a claim is being held, reduced, refused or paid at zero. RVRSL in this field means the claim has been reassessed and the assessed amount has been changed. (See the Special Processing Codes section in the Explanatory Code Listing.)
20. **Registration Number**
Not applicable to allied health practitioners.
21. **Recovery Code**
Not applicable to allied health practitioners.
22. **Total Amount to be Paid**
Total amount to be paid for services provided by practitioners in the business arrangement.
23. **Total Amount (RVRSL)**
Total amount being recovered from the business arrangement, if payments for previous claims were adjusted.
24. **Summary Total**
Summary of the amounts payable for services provided by each practitioner and a grand total amount payable to the business arrangement.
25. **Provider Name**
Name of each practitioner in this business arrangement who had claims processed.
26. **Assessed Amount**
Amount to be paid for each practitioner's services.
27. **Total Amount to be Paid**
Total amount to be paid to the business arrangement.

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

If you need to correct the data on a paid-at-zero claim or if you disagree with the reason why the claim was paid at zero, you must resubmit the claim with action code **C** (change) or **R** (reassess), as applicable. (See **3.3 Action codes** and **6.6 Following up on a claim – using the correct action code.**)

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

If you need to correct the data on a refused claim or if you disagree with the reason why the claim was refused, you must submit a new claim using action code **A**. Your submitter will assign a new claim number to the new submission. (See **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). You may notice that a paid claim included some incorrect information or that a processed claim should not have been submitted.

It is important that you review and understand these claim results. To help with this process, refer to the Explanatory Code List, the general rules in the Schedule of Benefits and the notes associated with the health service code in the Procedure List section of the Schedule.

If you determine that you have to resubmit a claim, be sure to 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.

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.

How to resubmit

Create a new claim with a new claim number.

- Use **action code A** (add).
- Include a base claim segment with all applicable data.

Note: Do not use action code C and the original claim number. The system will not recognize a claim number that was refused.

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.

- Use **action code R** (reassess).
- Complete the supporting text segment with information to support your reassessment request.
- A base claim segment is optional.

Resubmit the claim using the original claim number.

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

6.7 Checking the Statement of Account

Along with payments, Alberta Health and Wellness 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.

6.8 A sample Statement of Account

Alberta Health and Wellness PO Box 1360 Edmonton AB T5J 2N3	1 2009/05/01 13:07:13 Page 1
Statement of Account	
2 Dr. Andrew Boodek #555, 55 Alberta Way Anywhere AB T9T 9T9	5 Statement Date Year Month Day 2009 05 01
	6 Method of Payment: EFT
	7 SOA Reference Nbr: 686724000
3 Payee Dr. Andrew Boodek	
4 Expected Payment Date: 2009/05/01	
8 Total Amount:	714.69

9 Description	10 Reference Number	11 Date	12 Business Arrangement	13 Amount
14 Statement of Assessment	146098100	2009/04/24	9999-999	123.23
Provider ID 1992-39000 Dr. Andrew Boodek				123.23
Statement of Assessment	876198100	2009/04/24	9999-999	591.46
Provider ID 6843-39000 Dr. A. C. Doggle				591.46

15	
Description	Amount
Statement of Assessment	714.69
Total Amount	714.69

6.9 Statement of Account description

Please refer to **6.8 A sample Statement of Account** 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 and Wellness 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.

7.0 Helpful lists

7.1 Glossary

Accredited submitter

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

Action code

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

Alberta Health Care Insurance Plan (AHCIP)

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

Applied

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

Auxiliary hospital

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

Balance billing (or extra billing)

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

Basic health benefits

Services deemed medically required according to the *Canada Health Act* and provided by physicians, osteopaths and dental surgeons.

Benefit year

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

Bulletin

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

Business arrangement

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

By assessment

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

CCP

The Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures. CCP codes are widely used in practitioner benefits schedules.

Certification

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

Claim number

An individual number assigned to each claim by the submitter.

CLASS

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

Default skill

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

Dependant(s)

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

Diagnostic code

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

Direct billing

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

Direct deposit (or electronic funds transfer)

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

Discipline

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

Electronic claim submission

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

Explanatory code

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

Facility

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

Facility number

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

Fee modifier code

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

Functional centre

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

General hospital

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

Good faith policy

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

Governing organization

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

Health service code

A code that identifies services and procedures listed in the Schedules of Benefits. Complete code descriptions can be found in the Procedure List in the applicable Schedule.

Health service provider

A licensed individual providing health services.

H-Link

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

Modifier code

(See **Fee modifier code**.)

Nursing home

A facility designated for the provision of nursing home care.

Opting in

Participating in the publicly funded health care insurance plan.

Opting out

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

Paid at zero

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

PHN

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

Plan benefit

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

Practitioner

A licensed individual who provides health services.

Practitioner Identification Number (PRAC ID)

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

Provider

(See **Health service provider**.)

Registrant

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

Registration number

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

Resident of Alberta

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

Result code

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

Schedule of Benefits

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

Service provider

(See **Health service provider**.)

Service recipient

A person who receives health services (the patient).

Skill

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

Specialty

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

Stakeholder

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

Statement of Account

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

Statement of Assessment

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

Submitter

(See **Accredited submitter**.)

ULI

Unique Lifetime Identifier. (See **PHN**.)

Unlisted procedure

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

V (Varies)

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

7.2 The Procedure List

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

1. The date on which the Schedule was printed.
2. The Procedure List is up to date as of the date indicated.
3. Roman numerals and description for the anatomical region; e.g., XV. Operations on the Musculoskeletal System.
4. This field is a heading used to identify body part and type of procedures.
5. The health service code for the service performed.
6. A description of the health service code. In this example, it refers to anterior segmental osteotomy of the maxilla.
7. BASE amount is the fee for the service, before application of any modifiers. This may be a dollar amount or the code BY ASSESS. (The fee payable for a BY ASSESS procedure depends on supporting information that must be submitted with the claim.)
8. The ANE field indicates the anaesthetic fee for the service, if applicable. In the Schedules of Benefits where an anaesthetic fee is listed for a procedure, it would only be claimed by the physician providing the related anaesthetic service.
9. The NOTE field contains special instructions for a health service code.
10. The letter V beside the base rate means the fee payable varies according to the practitioner's skill code, specific modifiers on the claim and other variables.

7.3 A sample page from the Procedure List

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

Page 12
2
As of 2009/04/01

1
Generated 2009/04/22

3
XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

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

4 88.2 Incision of facial bone without division (cont'd)

88.29 Other incision of facial bone without division (cont'd)

	7	8
	BASE	ANE
5 88.29M Anterior segmental osteotomy of the maxilla	1,584.61	564.30
88.29T Oblique osteotomy of ramus That including bone graft	1,790.50	574.00
88.29U Osteotomy of condylar neck	1,584.61	1,128.60
88.29V Sagittal split osteotomy	1,584.61	598.50
88.29X Inverted L osteotomy	1,584.61	1,000.40
88.29Y Costeotomy	1,584.61	1,016.80
88.29DB Inverted L osteotomy including bone graft	1,932.88	754.40
88.29DC Osseodistraction and Bone Lengthening, including management of advancement	2,089.58	820.00
88.29DD Le Fort I	1,584.61	649.80
88.29DE Le Fort I with bone graft	1,932.88	754.40
88.29DF Le Fort I, segmental without bone graft	1,790.50	623.20
88.29DG Le Fort I, segmental with bone graft	2,113.11	718.20
NOTE: 88.29DJ, 88.29DK may be claimed in addition for harvesting.		
88.29CA Le Fort I in cleft palate	1,584.61	623.20
88.29DA Le Fort I in cleft palate	1,932.88	623.20
88.29N Le Fort II osteotomy	2,112.82	1,328.40
88.29FA Le Fort III osteotomy	2,288.90	1,476.00
88.29GA Posterior segmental osteotomy of the mandible	1,584.61	533.00
88.29HA Total dent-alveolar osteotomy of the mandible	1,584.61	1,016.80
88.29TA Posterior segmental osteotomy of the maxilla	1,584.61	590.40
88.29MA Lower Border osteotomy	1,584.61	574.00
88.29NA Removal of loose bodies	106.54	V 147.60
88.29PA Surgical lavage	255.69	136.80
9 NOTE: May not be claimed with diagnostic TMJ arthroscopy.		
88.29QA Surgical lysis of adhesions	106.54	V 131.20
88.29RA Mechanical debridement	106.54	V 131.20
88.29SA Laser debridement	106.54	V 139.40
88.29DH Harvesting of bone graft - Homologous graft, from the bank	56.89	102.50
88.29DJ Harvesting of bone graft - Autogenous bone graft, iliac crest	311.86	102.50
88.29DK Harvesting of bone graft - Autogenous bone graft, same or other site	161.30	102.50
88.29DL Harvesting of costal chondral graft, using chest wall, minor (one rib)	284.94	123.00
88.29DM Harvesting of costal chondral graft, using chest wall, major (two ribs or more)	627.08	196.80
88.29DN Harvesting of costal chondral graft, using chest wall, major with insertion of Marlex mesh	912.11	278.80

7.4 The Price List

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

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

1. 88.29M is the health service code. See the Procedure List for a description of this code.
2. \$1584.61 is the base fee for this procedure.
3. This field lists all modifier types applicable to this health service code.
4. A listing of all modifier codes that affect payment, applicable to this health service code. For example:
 - A ROLE modifier code entered on a claim indicates the function performed by the practitioner in providing the service (e.g., surgical assist).
 - SAU modifier code indicates the number of surgical assist time unit services that may be claimed. (Supporting text is required if this maximum is exceeded.)
5. The Y in this field identifies each explicit modifier. When applicable, these modifier codes must be manually entered on a claim prior to submission.
6. This field shows what effect the modifier has on the base amount. Example: When the modifier code SA is used and more than one call is entered on the claim, the implicit modifier SAU is assigned by the claims processing system. The base fee is then replaced by \$81.95 for the first hour of surgical assist time, plus \$20.34 is added for each additional call entered on the claim.
7. This field indicates the fee for each modifier code.
8. The category code for each health service code. The number 14 here indicates a major procedure.

7.5 A sample page from the Price List

ALBERTA HEALTH CARE INSURANCE PLAN							
Schedule of Dentistry Benefits							
Part C - Price List							
Generated 2009/04/22							
Page 43							
As of 2009/04/01							
-----MODIFIER-----							
1	2	3	4	5	6	7	8
HSC	BASE RATE	TYPE	CODE	EXPLCT	ACTION	AMOUNT	CAT
88.29M	1584.61	BMI	BMIANE	Y	Increase By	25%	14
		BMI	BMIANT	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	564.30	
		ROLE	ANEST	Y	Replace Base	17.10	
		ROLE	SA	Y	Replace Base	81.95	
		ROLE	SOSS	Y	Replace Base	253.71	
		ANU	ANU				
			1		For Each Call Pay Base At	100%	
			2-105		For Each Call Increase By	17.10	
		SAU	SAU				
			1		For Each Call Pay Base At	100%	
			2-21		For Each Call Increase By	20.34	
		SOSU	SOSU				
			1		For Each Call Pay Base At	100%	
			2-33		For Each Call Increase By	84.56	
		SURC	DEV	Y	Increase By	76.20	
		SURC	DNTAM	Y	Increase By	182.88	
		SURC	DNTPM	Y	Increase By	182.88	
		SURC	DWK	Y	Increase By	76.20	
		SURC	EV	Y	Increase By	44.69	
		SURC	NTAM	Y	Increase By	107.22	
		SURC	NTPM	Y	Increase By	107.22	
		SURC	WK	Y	Increase By	44.69	
		LVP	LVP75	Y	Reduce Base To	75%	
88.29T	1790.50	BMI	BMIANE	Y	Increase By	25%	14
		BMI	BMIANT	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	574.00	
		ROLE	ANEST	Y	Replace Base	17.10	
		ROLE	SA	Y	Replace Base	81.95	
		ROLE	SOSS	Y	Replace Base	253.71	
		ANU	ANU				
			1		For Each Call Pay Base At	100%4	
			2-105		For Each Call Increase By	17.10	
		SAU	SAU				
			1		For Each Call Pay Base At	100%	
			2-21		For Each Call Increase By	20.34	
		SOSU	SOSU				
			1		For Each Call Pay Base At	100%	
			2-33		For Each Call Increase By	84.56	
		SURC	DEV	Y	Increase By	76.20	
		SURC	DNTAM	Y	Increase By	182.88	
		SURC	DNTPM	Y	Increase By	182.88	
		SURC	DWK	Y	Increase By	76.20	
		SURC	EV	Y	Increase By	44.69	
		SURC	NTAM	Y	Increase By	107.22	
		SURC	NTPM	Y	Increase By	107.22	
		SURC	WK	Y	Increase By	44.69	
		LVP	LVP75	Y	Reduce Base To	75%	
88.29U	1584.61	BMI	BMIANE	Y	Increase By	25%	14
		BMI	BMIANT	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	1128.60	
		ROLE	ANEST	Y	Replace Base	17.10	
		ROLE	SA	Y	Replace Base	81.95	
		ROLE	SOSS	Y	Replace Base	253.71	
		ANU	ANU				
			1		For Each Call Pay Base At	100%	
			2-105		For Each Call Increase By	17.10	
		SAU	SAU				
			1		For Each Call Pay Base At	100%	
			2-21		For Each Call Increase By	20.34	
		SOSU	SOSU				
			1		For Each Call Pay Base At	100%	
			2-33		For Each Call Increase By	84.56	
		SURC	DEV	Y	Increase By	76.20	
		SURC	DNTAM	Y	Increase By	182.88	
SURC	DNTPM	Y	Increase By	182.88			

7.6 Alberta Health and Wellness resources

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

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

Practitioners are encouraged to make these resources easily accessible for reference and use by their staff as well. This will enable practitioner offices to become self-sufficient, and thus will help to maximize the time Alberta Health and Wellness staff can dedicate to other business matters that require direct intervention or immediate attention.



Note: The Schedules of Benefits are updated periodically. We recommend you use the most recent edition of the Schedule for your claim submissions. See the **Introduction** to this guide for information about obtaining a copy of the Schedule.

7.6.1 Contacting Alberta Health and Wellness by telephone

When you need to contact Alberta Health and Wellness by phone, you can use the numbers listed on the next page. Toll-free access from outside the Edmonton area is available by calling 310-0000 and, when prompted, entering the area code and number you wish to reach.

Some of these contact numbers use interactive voice response (IVR) technology, which makes them accessible for some services 24 hours a day, seven days a week. The option to speak with a telephone agent is available during Alberta Health and Wellness office hours, which are Monday to Friday from 8:15 a.m. to 4:30 p.m., except for government holidays.

Information about:

- Claim assessment or reassessments. **780-422-1600 ****
- General billing inquiries. (8:15 a.m. – 4:30 p.m.)

Information about:

- Practitioner or facility registration. **780-422-1522 ****
- Changes to address, skill, business arrangement. (8:15 a.m. – 4:30 p.m.)
- Direct deposit, banking details.

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

780-415-2288 **
(8:15 a.m. – 4:30 p.m.)

- Maximum of three PHNs per call.

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.)

Information about:

- H-Link submitter accreditation. **780-644-7643 ****
- Application support. (8:15 a.m. – 4:30 p.m.)

Request a replacement Statement of Assessment.

- You will need to provide your Business Arrangement number and the statement date. **780-415-8731**
(24 hour access)
The public also uses this number to request other information.
- Ensure 15 business days have elapsed since the statement date before calling.

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.

** To ensure Alberta Health and Wellness staff are available to provide practitioner and their staff with prompt and efficient service, please **do not give out these numbers** to the general public.

7.6.2 Contacting Alberta Health and Wellness in writing

Requests for clarification of general rules and billing policies must be submitted to Alberta Health and Wellness in writing. These requests can be submitted using any of the following methods:

Mail: Claims Management
Health Care Insurance Plan Administration Branch
Alberta Health and Wellness
P.O. Box 1360 Station Main
Edmonton AB T5J 2N3

Fax: 780-422-3552

E-mail: health.practitionerinquiries@gov.ab.ca



Note: You can also report your business mailing address changes using the above e-mail address.

7.6.3 Obtaining resource material from Alberta Health and Wellness

All forms required by practitioners can be printed from the Alberta Health and Wellness website at www.health.alberta.ca/AHCIP/forms-claims.html. **Exception:** The Request for Personal Health Numbers form - AHC0406 is **not** available online. To request a supply of this form, fax your request to 780-415-1704. (See **2.8 Patient PHN problems**.)

The Schedules of Benefits, Diagnostic Code List, Explanatory Code List and Facility Listing are available online at www.health.alberta.ca/professionals/Fees.html. CD-ROM copies can be ordered by faxing a request to 780-427-1093. (See **Introduction**.)

This Allied Health Practitioner's Resource Guide is updated as needed. Information about applicable Schedule of Benefits amendments and advice regarding claim submissions, clarification of assessment, etc., is communicated in Bulletins released by Alberta Health and Wellness. Bulletins are available online at www.health.alberta.ca/professionals/resources.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.