

Alberta Health and Wellness

Physician's Resource Guide

For physicians and their office staff

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

August 2011

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

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

Government
of Alberta



List of February 2010 changes to the Physician’s Resource Guide

- Updated departmental branch and unit names throughout
- Updated telephone numbers throughout
- Updated website addresses throughout
- Section 4.5 Prior approval for Saskatchewan residents
- Section 7.1 Glossary: “Dependant”, “Registrant”, “Registration number”

List of April 2011 changes to the Physician’s Resource Guide

- Changed “regional health authority” to “Alberta Health Services” throughout
- Introduction
- Section 1.5.4 The business arrangement and the submitter
- Section 1.6 Registering your facility
- Section 1.11 Alternate relationship plans
- Section 2.8 Patient PHN problems
- Section 3.4.1 In-Province provider base claim segment: “health service code”, “calls”, “claimed amount”
- Section 3.7 Billing tips to help you
- Section 4.7 Province/territory contact information and claim submission time limits
- Section 5.4 Sexually transmitted infections claims
- Section 5.8 Prior approval for special health care services provided elsewhere in Canada
- Section 5.9 Prior approval for special health care services provided outside Canada
- Section 7.1 Glossary: “Out-of-Country Health Services Committee”
- Section 7.2 Health service codes that require supporting text/documentation
- Section 7.7.3 Obtaining resource material from Alberta Health and Wellness
- Section 7.8 Key legislation/regulations

List of August 2011 changes to the Physician’s Resource Guide

- Section 5.9 Prior approval for health care services provided outside Canada

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Introduction

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

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

This guide is designed for use in conjunction with the Schedule of Medical Benefits, which consists of the following sections:

General Rules:	Defines the circumstances under which insured services are paid.
Procedure List	Lists insured diagnostic, therapeutic and surgical procedures. This section contains health service codes and descriptions, applicable notes, base payment rates and applicable anaesthetic rates.
Price List	Lists all health service codes and their applicable modifiers. This section indicates how fees are modified by specific circumstances. It displays the category code for each service so physicians can identify visits, tests, minor and major procedures.
Fee Modifier Definitions	Describes all implicit and explicit modifier codes used by the AHCIP processing system to determine amounts payable.
Anaesthetic Rates Applicable to Dental Services, Podiatry Services and Podiatric Surgery	Contains procedure and price list information for use by physicians who provide anaesthetic services for insured dental, podiatry and podiatric surgery services.

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

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

New physicians 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 from our office, you can fax a request to 780-427-1093. Be sure to include your PRAC ID with your request. (See **1.3 Registering as a new physician** for information about the PRAC ID.)

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.
Diagnostic Code Supplement	Provides codes for medical conditions. A diagnostic code must appear on all AHCIP claims except for pathology, radiology, anaesthesia and surgical assists.
Facility Listing	<p>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 care centres. Identifies the physical location where health services are performed. (See 7.1 Glossary for definitions of these facilities.)</p> <p>A facility number or a location code must appear on all claims to the AHCIP.</p> <p>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 physician who requested the number.</p>

You can access these documents from our website at www.health.alberta.ca/professionals/Fees.html. If you need a copy on CD-ROM from our office, you can fax a request to 780-427-1093.



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 physicians with other important information. We encourage you to share these Bulletins with your office/billing staff.

As with this Physician'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 physician

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

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

1.1 Claiming services from AHCIP

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

- eligible Alberta residents, and
- residents of other Canadian provinces/territories (except Quebec residents) under the medical reciprocal program. (See **4.0 Out-of-province patient claims**.)

Physicians may claim payment from the AHCIP directly, or they may bill the patient.



Note: Physicians may not charge a patient more than the AHCIP pays for insured services. If the patient is billed, the physician must submit a pay-to-patient claim to the AHCIP on the patient's behalf.

Claims are submitted to the AHCIP through an existing accredited submitter using the electronic H-Link method. Alternatively, physicians 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.
- Physicians may not claim for any service they provide to their children, grandchildren, siblings, parents, grandparents, spouse or adult interdependent partner, or any person who is dependent on the physician for support.
- When one physician sends a member of his/her family to another physician, the second physician may not claim for a consultation. A referral from a patient's family member is not considered a formal referral for the purposes of billing a consultation service.
- Claims that are the responsibility of the Workers' Compensation Board (WCB) are not to be submitted to the AHCIP. They should be submitted directly to the WCB. (See **5.7 Workers' Compensation Board (WCB) claims**.)

1.3 Registering as a new physician

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

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

Instructions for completing the AHC0912 form: (See 1.13 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 “Form F”, provided to you by the College of Physicians and Surgeons of Alberta.
- 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 physician must sign and date this section before this form is considered valid.



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

1.4 Other forms a physician may need to complete

A physician who is already registered and needs to change some of the information about their practice (business mailing address, business arrangement, skill, submitter, banking information, etc.) will need to complete one or more of the forms listed below. (See **1.13 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 business mailing address, please inform us if you change your home address.

1.5 The business arrangement

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

To make a change to an existing business arrangement or to request a new business arrangement, complete a Business Arrangement Request form - AHC0913. (See **1.13 Form samples**.)

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

Fee-for-service:	The traditional method of receiving payment from the AHCIP.
Locum tenens:	A physician who substitutes temporarily for another physician. (See 1.10 Locum tenens .)
Alternate relationship plan:	A mechanism to compensate physicians in a manner other than the traditional fee-for-service method. (See 1.11 Alternate relationship plans .)

1.5.1 The business arrangement and the physician'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 "Form F", provided to you by the College of Physicians and Surgeons of Alberta.
- Business Arrangement Request - AHC0913.
- If applicable, Business Arrangement/Service Provider Relationship - AHC0914. This identifies any other physician(s) who will also be billing through the business arrangement number (e.g., a clinic).

1.5.2 The business arrangement and the physician's default skill

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

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

When the Skill Code field on a claim to the AHCIP is left blank, the claim is automatically processed using the default skill. (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 physician is setting up a new business arrangement, they provide their direct deposit details in section E on the Practitioner Information form - AHC0912.
- When a new physician is joining an existing business arrangement (section F on the AHC0912 form), the direct deposit provision already established for that business arrangement applies.
- When a registered physician is setting up a new business arrangement, they provide their direct deposit information for that new business arrangement by completing a Business Arrangement Request form - AHC0913.
- A registered physician 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 will 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, except for locum business arrangements, **must** have an accredited submitter attached to them in order for claims to be submitted for payment. (See **1.10 Locum tenens** for more information about locum business arrangements.)

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

- If you are joining an existing business arrangement, the submitter for that business arrangement will handle your claims.
- If you are setting up your own practice or clinic, you will need to obtain the services of an accredited submitter; or you can apply to become your own submitter.
 - If you are using an existing accredited submitter, you and your submitter will need to complete a Submitter/Client Relationship for Electronic Claim Submission form - AHC2096.
 - If you want to be your own submitter, you will need to complete an 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 in Alberta, dial 310-0000 then enter 780-644-7463 when prompted. You can also send an email to health.hlink@gov.ab.ca.



Note: If you change submitters, we strongly recommend you set up a new business arrangement number for the new submitter. If you choose **not** to set up a new business arrangement for the new submitter, 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 (provider office, diagnostic imaging facility, etc.) 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 physicians work out of the location. Claims for services provided in the facility must include the facility number.
- Diagnostic imaging, stress testing, pulmonary function facilities and approved non-hospital surgical facilities require a letter from the College of Physicians and Surgeons of Alberta indicating that the facility or functional centre is accredited to perform its associated services.
- A facility may also have a three-digit number for use on claims for insured services contracted with Alberta Health Services. To ensure the correct facility number is used on a claim to the AHCIP, the physician must check with the facility operator to determine if the service is contracted with Alberta Health Services 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 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 physicians will also be submitting claims under your new business arrangement.
Facility Registration: AHC0910A	If you need to change the facility or governing stakeholder name.

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

1.10 Locum tenens

A physician who wishes to work as a locum tenens must have a locum business arrangement in their own name or in the name of their professional corporation. To obtain a locum business arrangement, complete the Business Arrangement Request form - AHC0913.

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

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

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

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

Payment options	Claim field requirements
1. Payment is to be made to the practice using the practice's submitter:	<ul style="list-style-type: none"> • Enter the practice's business arrangement number in the Business Arrangement field. • Leave the Locum Business Arrangement field blank.
2. Payment is to be made to the practice using the locum's submitter:	<ul style="list-style-type: none"> • Enter the practice's business arrangement number in the Business Arrangement field. • Enter the locum's business arrangement number in the Locum Business Arrangement field.
3. Payment is to be made to the locum using the locum's submitter:	<ul style="list-style-type: none"> • Enter the locum business arrangement number in the Business Arrangement field. • Leave the Locum Business Arrangement field blank.
4. Payment is to be made to the locum using the practice's submitter:	<ul style="list-style-type: none"> • Enter the locum business arrangement number in the Business Arrangement field. • Enter the practice's business arrangement number in the Locum Business Arrangement field.



Note: When submitting claims for services provided by a locum, the **locum's PRAC ID** must be entered in the PRAC ID field on the claim (to identify the service provider), regardless of which of the above payment options applies.

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

1.11 Alternate relationship plans

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

Any clinical ARP proposal to be considered for alternate funding must be submitted to the ARP Program Management Office. More information about ARPs is available from:

ARP Program Management Office
201, 12420 - 104 Avenue NW
Edmonton AB T5N 3Z9
Phone: 780-453-3130
Toll-free: 1-866-953-3130
Fax: 780-453-3599
Email: inquiries@arppmo.org
Website: www.health.alberta.ca/professionals/resources.html

1.12 Physicians opting in and out of AHCIP

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

1.12.1 Opted-in physicians

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

There are penalties for physicians who extra-bill. These penalties, which are identified in sections 9 through 15 of the *Alberta Health Care Insurance Act*, include recovery of the amount paid by the AHCIP as well as the amount paid by the patient. The physician may also be liable for a fine. If you wish to view this legislation, you can link to it from the Alberta Health and Wellness website at www.health.alberta.ca/about/health-legislation.html. An official printed version is available from the Alberta Queen's Printer at www.qp.alberta.ca, or you can visit or call the Alberta Queen's Printer Bookstore at:

Main Floor, Park Plaza
10611 - 98 Avenue NW
Edmonton AB T5K 2P7
Phone: 780-427-4952
Fax: 780-452-0668

To phone or fax toll-free, call 310-0000 and enter the phone or fax number at the prompt.

1.12.2 Opted-out physicians

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

Physicians who want to opt out must take all of the following steps at least 180 days prior to the effective date of opting out:

1. Notify the Minister via the Health Care Insurance Plan Administration Branch in writing, indicating the effective date of opting out. (See section 1.12.3 for the mailing address.)
2. Publish a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practises.
3. Post a notice of the proposed opting out in a part of the physician's office where it can be viewed by all patients.

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

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



Note: In the event that an opted-out physician is the only physician available to provide a service in an emergency, the opted-out physician may bill the AHCIP for the emergency service. In this situation, the opted-out physician cannot charge a patient over and above the amount listed for that service in the Schedule of Medical Benefits.

1.12.3 Opting back in to the AHCIP

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

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

Notifications from physicians to opt out and applications to opt back into the AHCIP must be sent to:

Professional and Facility Management
Health Care Insurance Plan Administration Branch
Alberta Health and Wellness
PO Box 1360 Station Main
Edmonton AB T5J 2N3

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

1.13 Form samples

Following are samples of the various forms a physician 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.

Government of Alberta

**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

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

If you are leaving this facility, will others continue to 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.)

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

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

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

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

College or association registered with _____

Date registered Year Month Day Licence number _____

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

_____ Year Month Day

_____ Year Month Day

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

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

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

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

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

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

Indicate which skill will be used on most claims _____

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

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

Effective Year Month Day I will be joining BA Number _____

Indicate which skill will be used on most claims _____

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

Practitioner signature _____ Phone number _____

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

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

Section G - Facility and functional centre information

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

New facility number effective

Year	Month	Day

Facility name

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

City/Town

Province

Postal code

Indicate the functional centre(s) in your facility

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

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

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

Practitioner's signature _____ Date _____

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

Information collected is used to enrol you for programs or benefits funded by Alberta Health 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.

**Government
of Alberta**

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

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

For AHW office use only

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

Section A - Type and date of change

	Business Arrangement number	Effective date
<input type="checkbox"/> Add me to the business arrangement (BA)	_____ - _____	Year: _____ Month: _____ Day: _____
<input type="checkbox"/> Change my start date with this BA	_____ - _____	Year: _____ Month: _____ Day: _____
<input type="checkbox"/> Change my BA default skill to _____	_____ - _____	Year: _____ Month: _____ Day: _____
<input type="checkbox"/> End my relationship with the BA	_____ - _____	Year: _____ Month: _____ Day: _____
BA contract holder name _____		
Practitioner name _____		Practitioner ID _____
Indicate the skill that will be used on most claims _____		

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

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

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

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

Information collected is used to enrol you for programs or benefits funded by Alberta Health 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.

AHC0914 (2010/04)



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 Chequing – attach a void cheque
or 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

Submitter certification and agreement

I hereby authorize this accredited submitter to submit my claims electronically on my behalf. I further certify that my agreement with the accredited submitter, who is party to this application, conforms fully to the Electronic Claims Submission Specifications Manual and the *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.

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

Signature(s) _____

Signature(s) _____

Name(s) _____

Name(s) _____

Date _____

Date _____

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

Information collected is used to enrol you for programs or benefits funded by Alberta Health and Wellness. It is collected under the authority of sections 20(b) and 27 of the *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 will allow 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 our 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 physicians and their staff to check a patient's PHN for validity and eligibility for coverage for a specific date. This service is available 24 hours a day, seven days a week, 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 on the date of service specified.
 - If the PHN is invalid (i.e., not structurally correct).
5. After the IVR system has processed your first inquiry, it will prompt you to press # if you wish to check another patient's PHN. You can check as many PHNs as you need to during the same phone call.



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

2.4 Patients who are not eligible

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

- Those who have active health coverage in another province. (Persons who have moved to Alberta recently and are still covered under the health plan of another province/territory.)
- 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 physicians 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. until 4:30 p.m. except on government holidays, and is for **exclusive** use of practitioner offices. Please **do not** give this number to the public, as it will affect our ability to provide prompt and efficient service to practitioner offices.



Note: A current Alberta address by itself does not mean a resident is covered by the AHCIP. Residents who have moved to Alberta may be covered by their previous home province/territory plan for up to three months. Physicians 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

1. Bill the patient directly (the amount charged for an insured service must not be more than what the AHCIP pays for the service) 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.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. If the patient produces a health insurance card from another province/territory where they claim to have coverage and the card appears to be valid, submit a medical reciprocal claim to Alberta Health and Wellness. (See **4.2 Submitting a claim under the medical reciprocal program.**)

You may want to confirm eligibility with the province of origin to ensure payment. (See sections **4.6** and **4.7** for health card and health care plan contact information.)

3. If your patient indicates they are not yet registered with the AHCIP but confirm they have lived in Alberta as a permanent resident for more than three months (not a tourist, transient or visitor), **and do not have coverage from their province of origin** you may submit a claim under the good faith policy. (See **5.1 Alberta's good faith policy**.)



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

2.8 Patient PHN problems

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

- Confirm that the PHN on your claim is correct (check for a clerical error). If applicable, submit a new claim with the correct PHN.
- Contact the patient to confirm the status of their health coverage. If you obtain a correct PHN, submit a new claim.
- If you cannot obtain a correct PHN, call our Registration Research unit. 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 they wish 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 (or, if applicable, their out-of-province registration number and province code).
- The practitioner identification number (PRAC ID) of the physician who provided the service.
- If applicable, the PRAC ID of the referring practitioner.

WHAT service was performed:

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

WHERE it occurred:

Enter the facility number.

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

WHEN it occurred:

Enter the date of service.

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

WHY the procedure was done:

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

- Diagnostic codes are **not** required for pathology, radiology, anaesthetic or surgical assist services.

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 **5.6 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
 - physician's PRAC ID
 - business arrangement number
 - locum business arrangement number

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

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

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

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

- Use the same claim number from the Statement of Assessment.
- You do not need a base claim segment or person data segment.
- You must **delete** the original claim if you want to change any of these details:
 - patient's personal health number
 - physician's PRAC ID
 - business arrangement number
 - locum business arrangement 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 physicians, and must be completed on every new claim. The data fields within this segment are:

- Claim Type:** Enter **RGLR** for all action code **A** (add) or **C** (change) claims.
- Leave this field blank for action code **R** (reassess) and **D** (delete) claims.
- PRAC ID:** Enter the practitioner identifier number (PRAC ID) of the physician who provided the service.
- Do not enter a professional corporation identifier number in this field or the claim will be refused.
 - It is **not** appropriate to claim your services under another physician's PRAC ID. Only the PRAC ID of the physician who provided the specific service is acceptable on the claim for that service.

Skill Code:

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

Physicians with more than one skill are assigned additional skill codes in accordance with documentation from the College of Physicians and Surgeons of Alberta.

- When submitting a claim for a service performed using your primary skill, you can leave this field blank providing you have indicated on your business arrangement that this primary skill is your default skill. The processing system will automatically process the claim using your default skill when the Skill Code field is blank.
- If submitting a claim for a service performed using a skill other than your primary skill, enter the other skill code in this field; otherwise, the system will default to the primary skill code and you will be paid the primary skill rate.
- If you have more than one skill and you have not designated a default skill, enter the skill code that is most appropriate for the service being provided.

Service Recipient PHN:

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

- If the claim is for a newborn whose PHN is unknown or if it is a first-time claim under the medical reciprocal program, leave this field blank and provide information in the person data segment of the claim. (See **3.4.2 Claim Person Data Segment**.)

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

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

Service Recipient Other Identifier:

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

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

- Health Service Code:** Enter the appropriate code from the Procedure List in the Schedule of Medical Benefits.
- Procedures claimed under section 99.09 (Procedures not elsewhere classified) require supporting text/documentation. (See **3.8 Submitting claims for unlisted procedures.**)
 - It is **not** appropriate to submit a claim using a code from the 99.09 section when a specific health service code for the service provided is listed elsewhere in the Procedure List.
 - When an unlisted service is provided, it is **not** appropriate to submit a claim using an established health service code that is similar to the actual procedure performed.
- Service Start Date:** Use YYYYMMDD format to enter the date on which the service was performed.
- For hospital visits (health service code 03.03D), enter the date of the **first** day of consecutive hospital visit days. In the Calls field, enter the number of consecutive days of visits, to a maximum of 99 days.
For a patient in hospital longer than 99 days, start a new claim for the additional days, beginning at call one (1). Enter the original admission date in the Hospital Admission Date/Originating Encounter Date field.
 - Except for hospital in-patient services, claims may not be submitted more than 180 days from the date of service.
- Encounter Number:** This field defines the number of **separate** times the physician saw the same patient on the same day either for a different condition, or for a condition that has worsened.
- Most often, the encounter number entered is one (1). An additional separate encounter would be encounter 2 on a separate claim.
 - A different encounter number **does not apply** to continuation of services or to services initiated by the physician to a specific patient on the same day. Claims for these services must be submitted with the same encounter number. (See general rule 1.14 in the Schedule.)
 - “Encounter number” and “calls” **do not mean the same thing**. Do not use encounter numbers to denote the number of services (calls) you are claiming for a health service code. If billing for medical emergency detention (13.99J), use the Encounter Number field and the Calls field. This combination allows you to record time on a cumulative basis for the time spent with a specific patient on a given day. All 13.99J services provided to a patient on the same day must be submitted with the same encounter number and the appropriate number of calls.

- 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.
 - Diagnostic codes are **not** required for pathology, radiology, anaesthetic or surgical assist services. However, if an anaesthetist bills a visit or consultation, a diagnostic code is required.
- Calls:** Enter up to three digits to identify the number of calls for the health service code you are claiming, or the number of units for time-based services you provided.
- Where applicable, the Price List in the Schedule of Medical Benefits identifies the maximum calls allowed for each health service code, or the number of units for time-based services.
 - If the number of services you provided exceeds the maximum specified for that health service code, submit your claim with the actual number of calls plus supporting text or documentation for the claim to be considered for payment. Claims without this information will be automatically reduced to the maximum calls specified in the Price List.
- Note:** This **does not apply** to health service codes where a maximum fee is specifically indicated in the Procedure List or Price List. The listed maximum fee will not be exceeded for these services regardless of any explanatory text submitted.
- Health service code **03.03D** is 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., physician's office, hospital, etc.).
- Leave blank if the service was performed in a location that is not a registered facility. (See **Location Code** field.)

- Functional Centre:** Complete this field only if the service was performed at a registered facility that has functional centre codes. Example: the neonatal intensive care unit within a hospital is a functional centre.
- To avoid claim refusal, be sure to use the appropriate functional centre code. Refer to the Facility Listing (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.
- Originating Facility:** This field is completed in addition to the facility number/location code when service components were performed at two different facilities. Example: when an x-ray is taken in one facility and then interpreted in another facility.
- If applicable, enter the facility number where the service originated.
- Originating Location:** This field is completed in addition to the facility number/location code when the physician encounters the patient at a location other than where the service occurred and that location is not a recognized facility.
- If applicable, enter HOME (for patient's home), or OTHR (other).
- Business Arrangement:** Enter the business arrangement number under which the physician is making the claim. (See **1.0 AHCIP Basics for the Physician**.)
- Locums must have their own business arrangement. (See **1.10 Locum tenens**.)

- Pay-to Code:** Enter the applicable code to identify the person or organization that is to receive the claim payment:
- BAPY** (Business arrangement payee) – Used most often, this code is used to pay the physician, clinic or professional corporation as defined in the business arrangement.
 - CONT** (Contract holder) – Pay the AHCIP registrant (head of the family).
 - RECP** (Service recipient) – Pay the patient.
 - PRVD** (Service provider) – Pay the physician. This code is not often used; BAPY is used for direct provider payment.
 - OTHR** (Other) – Someone other than the above. (See **Pay-to PHN** field.)
- A patient under age 14 cannot be the payee. If you want the patient's parent to be paid, enter CONT. For a guardian or other responsible party to be paid, enter OTHR. (See **Pay-to-PHN** field.)
- Pay-to PHN:** If you enter OTHR in the Pay-to Code field and you know the other person's personal health number, enter it here.
- If you do not know the PHN, fill out a person data segment for the payee.
- Locum Business Arrangement:** When a physician performs a service as a locum tenens for another physician, the business arrangement number of the locum physician or the other physician may be entered here, depending on who is to receive payment and which submitter is to be used. (See **1.10 Locum tenens** for locum option details.)
- Referral PRAC ID:** If the service was provided because of a referral, enter the referring provider's PRAC ID.
- General rule 4.4.8 in the Schedule lists the health service codes that require a referral PRAC ID.
 - **Do not** enter a professional corporation identifier number in this field or the claim will be refused.
 - If the service was referred from an out-of-province provider, leave this field blank. (See **Out-of-Province Referral Indicator** field.)
- Out-of-Province Referral Indicator:** This field is required **only** for Alberta patients who are referred by an out-of-province physician.
- Enter Y if a provider outside Alberta referred the patient for the service. Complete a person data segment for the out-of-province provider.
 - **Do not** complete this field on medical reciprocal claims.

Recovery Code:	If the claim is a medical reciprocal claim, enter the out-of-province patient's home province recovery code in this field. (See 4.6 Province/territory recovery codes and card samples.)
Chart Number:	This field is reserved for physician use. You can enter up to 14 alpha or numeric characters as a source reference or other type of file identifier.
Claimed Amount:	If the claim is "by assessment" or for an unlisted procedure, enter the fee requested. You also need to provide supporting text or documentation. (See 3.8 Submitting claims for unlisted procedures.) <ul style="list-style-type: none"> • Claimed amount is not required for other health service codes unless you are requesting a lower fee than what is listed in the Schedule.
Claimed Amount Indicator:	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.
Confidential Indicator:	Enter Y if the patient has asked that a service not be reported on their Statement of Benefits Paid. (See 5.3 Confidential claims.)
Good Faith Indicator:	Enter Y if submitting under the good faith policy. (See 5.1 Alberta's good faith policy.) <ul style="list-style-type: none"> • 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: <p style="margin-left: 20px;">LVBR (live birth) MULT (multiple birth) STBN (stillborn) ADOP (adoption)</p> <ul style="list-style-type: none"> • You must also complete a person data segment for the newborn. • Once you know the newborn's PHN, you can enter it in the Service Recipient PHN field on any future claims. You will not need a newborn code or a person data segment. • If this is a medical reciprocal claim and you do not know if the newborn was assigned a PHN for processing purposes, enter the mother's/guardian's out-of-province registration number in the Service Recipient Other Identifier field and in the person data segment for the newborn. (See 4.2 Submitting a claim under the medical reciprocal program.)

**Paper Supporting
Document Indicator:**

Enter Y if supporting documentation will be sent separately.

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

**Hospital Admission Date/
Originating Encounter
Date:**

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

Hospital visits:

- When claiming health service code 03.03D, enter the date of admission here. Also enter the number of consecutive hospital visit days in the Calls field. (See **Service Start Date** and **Calls** fields for information about patients in hospital longer than 99 days.)
- Non-consecutive hospital visit days also require a hospital admission date for each non-consecutive visit. Create a separate claim after each interruption in consecutive hospital days.
- If you are a physician taking over hospital care from another physician (see general rule 4.10 in the Schedule) and claiming for your services, enter the date of the patient's hospital admission in this field.

Originating facility:

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

Chronic care visits:

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

3.4.2 Claim person data segment – CPD1

This segment must be completed for:

- A patient (RECP) who does not have a PHN or does not know their PHN (i.e., good faith claim – see **5.1 Alberta's good faith policy**).
- A newborn patient without a PHN. (See **5.2 Newborn claims – Alberta residents.**)
- An out-of-province patient eligible under the medical reciprocal program who has not been assigned an Alberta PHN for processing purposes. (See **4.2 Submitting a claim under the medical reciprocal program.**)
- An “other” payee (OTHR); i.e., when someone other than the patient or AHCIP registrant (head of the family) has paid the claim and now wants to be reimbursed.

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

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

3.4.3 Claim supporting text segment – CST1

Use this segment only if the claim you are sending requires supporting text. When required, this segment is sent at the same time the base claim segment is submitted. (See **7.2 Health service codes that require supporting text/documentation.**)

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

3.4.4 Supporting text cross reference segment – CTX1

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

3.5 Mandatory claim fields and segments

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

If the claim involves ...	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. the medical reciprocal program:	<ul style="list-style-type: none">✓ recovery code✓ out-of-province registration number✓ newborn code (if applicable)✓ out-of-province registration number for mother/guardian of a newborn (if applicable)✓ person data segment (if PHN is not known)
3. good faith:	<ul style="list-style-type: none">✓ good faith indicator (enter Y)✓ person data segment
4. pay-to code OTHR:	<ul style="list-style-type: none">✓ pay-to PHN field or person data segment
5. out-of-province referral:	<ul style="list-style-type: none">✓ out-of-province referral indicator✓ person data segment
6. confidential claim:	<ul style="list-style-type: none">✓ confidential indicator (enter Y)

3.6 Modifier codes

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

All current modifier codes and their explanations are listed in the Modifier Definitions section in the Schedule of Medical Benefits. The Price List section in the Schedule lists the specific modifiers that apply to each health service code. (See **7.6 A sample page from the Price List.**)

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

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

- **Role** – Identifies the physician's function at the time service was provided; e.g., anaesthetist, surgical assistant, etc.
(When a claim for a surgical procedure is submitted without a role modifier, it is assumed to be the claim from the surgeon.)
- **Services unscheduled** – Identifies the time block during which a physician provided unscheduled services for a hospital patient (in-patient, outpatient or emergency department).

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

Two implicit modifier examples are:

- **Tray** – A specified amount is automatically added to the base amount on a claim for a procedure entitled to receive a tray fee.
- **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 Billing tips to help you

Becoming familiar with the following information about some of the most commonly billed services can help physicians and their billing staff with the preparation of claims to the AHCIP.

- Visits and consultations:**
- Health service codes for these services are found under section 03 “Clinical Evaluation and Examination” in the Procedure List and Price List in the Schedule of Medical Benefits.
 - General rule 4.3 in the Schedule determines whether the consultation was comprehensive, limited or time-based.
 - The amount payable for the service varies according to the physician’s skill. The Price List contains these different rates.
- Special callbacks:**
- Claims for special callbacks to hospital in-patient, outpatient and emergency departments must meet the criteria listed in general rule 15.3 in the Schedule.
 - Benefits may **not** be claimed for subsequent patients seen during the same callback or in association with another service during the same encounter.
 - For special callbacks to hospital emergency/outpatient department, auxiliary hospital or nursing home, see general rule 5.2 in the Schedule and the notes following health service code 03.03MD.
 - For special callbacks to hospital outpatient departments, auxiliary hospitals and nursing homes, benefits may be claimed for second and subsequent patients during the same callback.
- Services uncheduled:**
- When a hospital service occurs outside the physician’s usual working hours (see general rule 15.7 in the Schedule), enter a "services uncheduled" modifier in the Modifier field.
 - For time blocks, refer to the modifier definitions.
 - Physicians who are working scheduled shifts in a hospital setting or are initiating services (e.g., weekend rounds) **may not** claim for callbacks or the surcharge modifier. **Exception:** physicians on rotation duty who are eligible to claim the rotation duty off-hours benefits as outlined in general rule 5.1.1 in the Schedule.
- LEVL:**
- This implicit modifier refers to the variation in payment for health service code 03.03D based on the number of consecutive days the physician visited the patient in hospital. The payment level is based on the hospital admission date and the physician’s skill code.
- Transfer of care:**
- When a second physician takes over the care of a patient from another physician in the same facility as set out in general rule 4.10 in the Schedule, modifier TOC must be entered on the second physician’s claim. The patient’s original admission date must also be entered.

Lesser value procedure:

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

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

Variable anaesthetic:

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

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

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

Time-based services:

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

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

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

Tray service:

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

If trays are provided by a hospital for an outside surgical suite **at no cost**, only the fee for the procedure should be entered, and Y should be entered in the Claimed Amount Indicator field.

Claims submitted for services performed in a non-hospital surgical suite contracted by Alberta Health Services will automatically be modified to deduct tray services.

3.8 Submitting claims for unlisted procedures

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

- 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 (99.09A to 99.09V) from the unlisted procedures section of the Schedule.
- When preparing a claim for 99.09A to 99.09V, 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.

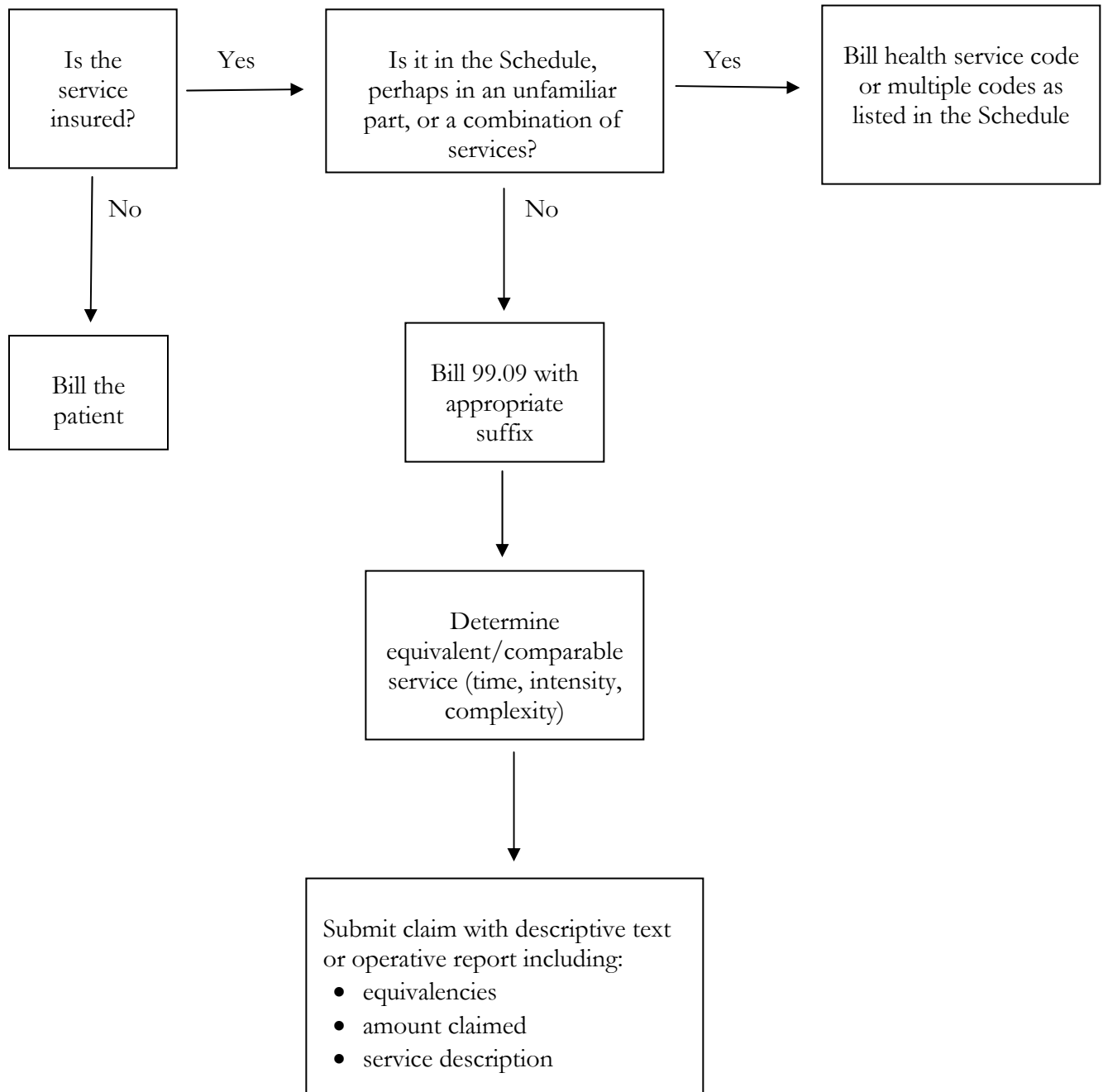
Alberta Health and Wellness assesses claims for unlisted services by comparing the service provided and the fee claimed with similar or comparable services listed in the Schedule. The assessment will be based on information concerning the time, complexity and intensity of the service, as provided on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

4.1 Three ways a physician can claim

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

1. Submit a claim to the AHCIP for processing through the medical reciprocal program. To do this, **you must see** the patient's provincial health care card. (See **4.2 Submitting a claim under the medical reciprocal program.**)



Note: Quebec does not participate in the medical reciprocal program. Patients from Quebec should be billed directly for medical services. (See item 3 below.)

2. If the patient did not present a valid health insurance card, or if the service is not eligible under the medical reciprocal program (see **4.4 Services excluded from the medical reciprocal program**), complete an Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. (See section **4.8** for a form sample.)

Submit the claim to the patient's home province or territory for payment consideration. (See **4.7 Province/territory contact information and claim submission time limits.**)

3. Bill the patient directly. Provide them with a completed Out-of-Province Claim for Physician/Practitioner Services form - AHC0693. (See section **4.8** for a form sample.) The patient may submit the claim to their home province health plan for reimbursement. A copy may be retained in the physician's office as a record of payment.

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



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 physician. 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.

4.2 Submitting a claim under the medical reciprocal program

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

To claim under the medical reciprocal program:

- The service provided must be insured under the AHCIP.
- The service must not appear on the excluded services list. (See **4.4 Services excluded from the medical reciprocal program.**)
- The patient must show you a current health insurance card from their province/territory of residence. (See **4.6 Province/territory recovery codes and card samples.**)
 - Confirm the card is in the name of the patient by requesting picture identification.
 - Confirm the card is valid for the date(s) you are providing a service by checking its effective and expiry dates (if indicated).
 - You may wish to make a copy of the card for your files.

When a physician submits a medical reciprocal claim for a new out-of-province patient, Alberta Health and Wellness assigns an Alberta PHN to the patient for processing purposes. This PHN has **no Alberta coverage eligibility** associated with it. Following are two situations for which specific information must be provided on the claim:

1. The physician does not know if the out-of-province patient was previously assigned an Alberta PHN for processing purposes:

Complete these fields:

- **Base Claim Segment:**
 - ✓ Service recipient other identifier (the patient's home province registration number)
 - ✓ Recovery code (the code for the patient's home province)
- **Person Data Segment:**
 - ✓ Person type (RECP - service recipient)
 - ✓ Surname
 - ✓ First name
 - ✓ Middle name (if known)
 - ✓ Birthdate (YYYYMMDD)
 - ✓ Gender code (M or F)
 - ✓ Home province address. Do not use dashes, abbreviations or punctuation, or the claim will be refused.

2. The patient is a newborn whose mother/guardian is an out-of-province resident and the physician does not know the Alberta PHN assigned to the newborn for processing purposes.

Complete these fields:

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

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

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

- Enter the patient's name on your claim exactly as it is displayed on their health care card.
- Double-check the registration number and province code, and ensure they have been entered accurately on the patient's chart and on the claim.
- Provide all applicable information in the patient's person data segment, including the complete date of birth (YYYYMMDD) and the correct gender code.
- Include text only for "by assessment" claims or when the number of calls for the health service code is greater than the maximum indicated in the Price List of the Schedule of Medical Benefits.



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

4.3 Claim types excluded from medical reciprocal billing

- Claims for Quebec residents cannot be submitted to the AHCIP, as Quebec does not participate in this program. You can bill the patient directly or complete an Out-of-Province Claim for Physician/Practitioner Services form - AHC0693 and forward it to Quebec's health plan. (See section 4.7 for the address.)
- Good faith claims cannot be submitted for out-of-province patients. The good faith policy applies only to patients believed to be Alberta residents. (See 5.1 **Alberta's good faith policy**.)
- Workers' Compensation Board (WCB) claims, including claims for out-of-province patients working in Alberta, must be submitted directly to the WCB.
- Confidential claims should be submitted to the patient's home province health plan for payment or billed to the patient. (See 5.3 **Confidential claims**.)

4.4 Services excluded from the medical reciprocal program

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

- Cosmetic surgery for alteration of appearance
- Sex-reassignment surgery
- Surgery for reversal of sterilization
- Therapeutic abortions (health service codes 86.41, 87.0A, 87.29A)
- Routine periodic health exams, including any routine eye exams
- In-vitro fertilization or artificial insemination
- Lithotripsy for gallbladder stones
- Treatment of port-wine stains on other than the face or neck, regardless of method of treatment
- Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- Services to persons covered by other agencies; RCMP, Canadian Forces, WCB, Veterans Affairs Canada, Correctional Service of Canada, etc.
- Services requested by a third party (e.g., driver's licence, employment medical)
- Team conference(s) (health service codes 03.05JA, 03.05T, 03.05U, 03.05V, 03.05W, 03.05Y, 08.11B, 08.19F, 08.19H, 08.19J, 08.19K)
- Genetic screening and other genetic investigation, including DNA probes
- Procedures still in the experimental/developmental stage
- Anaesthetic services and surgical assistant services associated with any of the above

4.5 Prior approval for Saskatchewan residents

Residents of Saskatchewan must have prior written approval from Saskatchewan Health to obtain insured cataract surgical procedures or magnetic resonance imaging services provided in **non-publicly funded facilities** outside their home province. They also require prior written approval for insured bone mineral density testing provided in **any facility** outside Saskatchewan. Where applicable, the AHCIP processing system flags the associated health service codes to check for prior approval, and claims submitted for services without prior approval will not be paid.

The physician, hospital or non-publicly funded facility where the services will be performed usually make requests for prior approval on the patient's behalf. Further information regarding prior approval for these services is available from Saskatchewan Health by contacting:

Dr. Dan Ash
Telephone: 306-787-3445
Fax: 306-787-3761

or

Dr. Jim Coucill
Telephone: 306-787-7430
Fax: 306-787-3761

4.6 Province/territory recovery codes and card samples

The recovery codes and health number formats for the other Canadian provinces (except Quebec) and territories are shown below. Samples of all province and territory health cards are displayed on the next page.

Unless otherwise indicated, all health cards display an expiry date. A health card with a year and month expiry date is valid until the end of the month shown on the card, unless otherwise determined by the patient's home province health care plan.

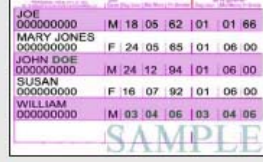
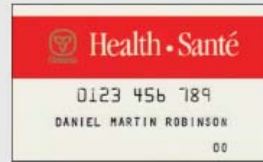
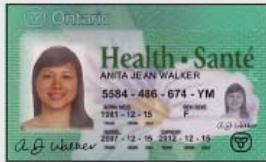
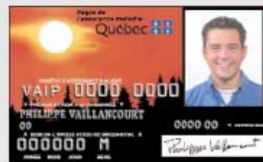
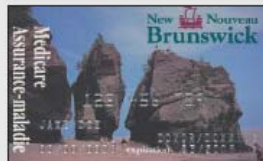
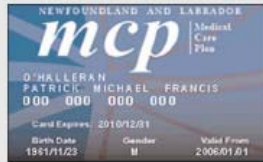
Province/territory	Recovery code	Health number format
British Columbia *	BC	10 numeric characters
Manitoba *	MB	9 numeric characters
New Brunswick	NB	9 numeric characters
Newfoundland and Labrador	NL	12 numeric characters
Northwest Territories	NT	1 alpha character followed by 7 numeric characters
Nova Scotia	NS	10 numeric characters
Nunavut	NU	9 numeric characters
Ontario **	ON	10 numeric characters
Prince Edward Island	PE	8 numeric characters
Saskatchewan	SK	9 numeric characters
Yukon	YT	9 numeric characters

* No expiry date displayed on health card.

** Expiry date on picture health card only.



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



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

NCN1353 (2008/03)



4.7 Province/territory contact information and claim submission time 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: 3 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 NT 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
P.O. 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

* Quebec does not participate in the medical reciprocal program.

4.8 A sample out-of-province claim form - AHC0693

OUT-OF-PROVINCE CLAIM FOR PHYSICIAN/ PRACTITIONER SERVICES

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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 to patient/contract holder

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

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

PHYSICIAN'S/PRACTITIONER'S NAME AND INITIALS		SPECIALITY <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)		SPECIALITY	
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		

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

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		

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, submit a medical reciprocal claim (see section **4.2**), or bill the other insurer, or bill the patient directly and provide them with a claim to submit to their insurer (see section **4.1**).

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 physician 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 physician; 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 Confidential claims

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

If the patient does not want a particular service to be shown on the Statement of Benefits Paid, enter "Y" in the Confidential Indicator field on the claim. (See **3.4.1 In-Province Provider Base Claim Segment**.) This must be done by the **physician/billing staff**, as Alberta Health and Wellness does not accept requests from **patients** to remove confidential services from the Statement of Benefits Paid.

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

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



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

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

5.4 Sexually transmitted infections claims

Claims for treatment of sexually transmitted infections can be submitted to the AHCIP if the patient is:

- Registered with the AHCIP, or
- Eligible under Alberta's good faith policy, or
- A resident of another province, eligible under the medical reciprocal program (See Note in **5.3 Confidential claims**.)

However, if the patient is:

- Not eligible for AHCIP coverage, or
- A transient, refugee, etc., or
- Not eligible under the medical reciprocal program, or
- A resident of Quebec, or
- A non-Canadian unable to pay for the service, you should **submit a paper claim to Alberta Health Services** at the address below:

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

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

5.5 Third-party service requests

Patient examinations performed at the request of a third party for their exclusive use are not insured services under the AHCIP. Payment for these types of service is the responsibility of the third party or the patient. Examples of third party-requested services include but are not limited to examinations for:

- Evidence in a police investigation
- Employment, insurance or sports purposes
- Driver's licences for individuals under the age of 74.5 years.

However, when a third party (police, social worker, colleague, etc.) brings a patient to a physician because the patient requires medical attention (for example, due to physical and/or emotional trauma), the physician may submit a claim to the AHCIP for that treatment, **provided** the patient is an Alberta resident or is eligible under the medical reciprocal program. Patients who are not eligible for payment of these medically required services by the AHCIP should be billed directly or a claim should be submitted to another health plan or insurer, as applicable.

5.6 Outdated claims

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

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

Manager, 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
Email: health.practitionerinquiries@gov.ab.ca

5.7 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.

If a patient requires WCB **and** non-WCB services in the same visit, the service relating directly to the work-related injury is to be billed directly to the WCB. Services that are unrelated to the WCB claim may be submitted to the AHCIP using health service code 03.01J.

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



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

5.8 Prior approval for special health care services provided elsewhere in Canada

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

However, some hospitalization and medical treatment services provided elsewhere in Canada fall **outside** the interprovincial reciprocal billing process. In these cases, prior approval for funding of these services is required from Alberta Health and Wellness. Prior approval requests will be considered if the services are:

- Medically required,
- Unavailable in Alberta,
- Insured medical, oral surgical and/or hospital services, and
- Not experimental or in the research stage.

An example of specialized health care services not currently available in Alberta but available elsewhere in Canada, and for which prior approval is required, is gamma knife radiosurgery for neurological conditions (see Bulletin Med 90 for information). Prior approval requests for funding of other services not available in Alberta but available elsewhere in Canada will be considered on a case-by-case basis. Examples of services that can be provided with prior approval include:

- high-risk prenatal health conditions
- certain types of cancer therapies
- complicated cases of laser assisted lead extraction
- percutaneous heart valve replacements

Prior approval requests must be submitted by the physician responsible for the patient's care, or by a specialist involved in the care, and must include:

- Patient identification information,
- Definition of the problem (diagnosis),
- Specific treatment requested and the duration of the treatment,
- Reason why Alberta treatment is not being used,
- Follow-up arrangements.

Prior approval requests must be sent to:

Manager, Out-of-Province/Out-of-Country Special Programs
Health Care Insurance Plan Administration Branch
Alberta Health and Wellness
PO Box 1360 Station Main
Edmonton AB T5J 2N3

5.9 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 Medical Benefits and relevant general and assessment rules. The claim is then either paid in full, paid at a reduced rate, paid at zero, refused, or held.

A held claim is assessed manually. Either it will be found valid and processed for payment, 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

4 Statement Date: 2007/11/02
Page 1

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

STATEMENT OF ASSESSMENT

5 Reference Nbrs
130509710

865187900

6
Sequence Nbr
01

Business Arrangement 9999-999 2
Expected Payment Date 2007/11/09 3

7 Patient Name	10 Chart Number	PHN	12 Claim Number	13 Service Start Date	14 Service Code	15 Claimed Amount	16 Assessed Amount	Mod Code	17 Mod Code	Mod Code	18 Result Code	Exp Code	19 Exp Code	20 Registration Number	21 RC
7 Boodek, Andrew	8	1992-39000													
9 Banery, Marvin	11	72636-9000	ELA07BA0000793	2007/10/01	03.03A	0.00	24.29				APLY				
Lodger, Beatrice	39053 35D	72685-9010	ELA07BA0000804	2007/10/05	03.05P	0.00	115.25				APLY				
Chipmon, Steve	39053-39D	91450-9004	ELA07BA0000708	2007/10/12	10.33A	0.00	36.79				APLY				
Quastell, Loni	39053-21C	92730-9106	ELA07BA0000808	2007/10/11	03.03B	0.00	32.37				APLY				
22 Total Amount to be Paid														208.70	
23 Total Amount (RVSL)														0.00	
7 Doggle, A.C.	8	6843-39000													
Parsill, Judy		23735-9000	ELA07BJ0000806	2007/10/05	48.12	0.00	1484.32				APLY				
Rutlatch, Craig		37735-9000	ELA07BJ0000608	2007/10/09	48.19A	0.00	285.39				APLY				
Owins, Ollie		92649-9000	ELA07BJ0000592	2007/10/12	49.7A	0.00	530.82				APLY				
Total Amount to be Paid														2300.53	
Total Amount (RVSL)														0.00	
24 Summary Total															
25 Provider Name														26 Assessed Amount	
Boodek, Andrew														208.70	
Doggle, A.C.														2300.53	
27 Total Amount to be Paid														2509.23	

6.4 Statement of Assessment 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. **Physician**
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 physician.
11. **PHN**
Personal health number identifying each patient.
12. **Claim Number**
Number assigned to each claim by the submitter.
13. **Service Start Date**
Date the service was performed, started or received.
14. **Service Code**
Unique code identifying the health service provided.

15. **Claimed Amount**
Amount claimed for the service provided.
16. **Assessed Amount**
Amount paid after application of assessment rules and other criteria.
17. **Modifier Code**
Explicit modifier code(s) affecting payment of a health service code.
18. **Result Code**
Code identifying whether a claim is being applied, held or refused.
19. **Explanatory Code**
Code explaining the reason a claim is being held, reduced, refused or paid-at-zero. RVRSL in this field means the claim has been reassessed and the assessed amount has been changed. (See the Special Processing Codes section in the Explanatory Code Listing.)
20. **Registration Number**
Out-of-province registration number of the patient (applies to medical reciprocal program claims only).
21. **Recovery Code**
Code identifying the home province that will be invoiced to reimburse the AHCIP for claim expenses (applies to medical reciprocal program claims only).
22. **Total Amount to be Paid**
Total amount to be paid for services provided by physicians in the business arrangement.
23. **Total Amount (RVRSL)**
Total amount being recovered from the business arrangement, if payments for previous claims were adjusted.
24. **Summary Total**
Summary of the amounts payable for services provided by each physician and a grand total amount payable to the business arrangement.
25. **Provider Name**
Name of each physician within this business arrangement who had claims processed.
26. **Assessed Amount**
Amount to be paid for each physician's services.
27. **Total Amount to be Paid**
Total amount to be paid to the business arrangement.

6.5 Result codes

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

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

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

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

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

If you need to correct the data on a refused claim or if you disagree with the reason why the claim was refused, you must submit a new claim using action code A. Your submitter will assign a new claim number to the new submission. (See **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 Medical 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 P.O. Box 1360 Edmonton AB T5J 2N3	1 2007/11/09 01:24:26 Page 1		
Statement of Account				
2 Dr. Andrew Boodek #555, 55 Alberta Way Anywhere, AB T9T 9T9	5 Statement Date Year Month Day 2007 11 09			
	6 Method of Payment: EFT			
	7 SOA Reference Nbr: 972258640			
3 Payee Dr Andrew Boodek				
4 Expected Payment Date: 2007/11/09				
	8 Total Amount:	3298.59		
9 Description	10 Reference Number	11 Date	12 Business Arrangement	13 Amount
14 Statement of Assessment	788691401	2007/11/01	9999-999	792.43
Provider ID 6843-39000 Dr. A.C. Doggle	792.43			
Statement of Assessment	130509710	2007/11/02	9999-999	2509.23
Provider ID 1992-39000 Dr. Andrew Boodek	2509.23			
15 Description	Amount			
Statement of Assessment	3301.66			
Total Amount:	3301.66			

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 physicians.

Action code

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

Alberta Health 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.

Alternate relationship plan (ARP)

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

Applied

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

Auxiliary hospital

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

Balance billing (or extra billing)

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

Basic health benefits

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

Benefit year

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

Bulletin

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

Business arrangement

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

By assessment

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

CCP

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

Certification

Official recognition by a licensing professional body that a physician has qualifications or capabilities to perform specific health services. Evidence of certification must be provided to Alberta Health 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.

Community mental health clinic

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

Confidential claims

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

Default skill

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

Dependants

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

Diagnostic code

A code that identifies a specific medical condition. It may have three to six characters, including a decimal point. A diagnostic code must appear on all AHCIP medical claims except for pathology, radiology, anaesthesia and surgical assists.

Direct billing

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

Direct deposit (or electronic funds transfer)

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

Discipline

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

Electronic claim submission

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

Excluded services

Medical services not payable under Canada's medical reciprocal program. (See **4.4 Services excluded from the medical reciprocal program** for a complete list.)

Explanatory code

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

Facility

The physical location, such as a hospital or clinic, where health services are routinely provided. All formally recognized or accredited facilities are registered by Alberta Health 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 physician. Implicit modifiers are entered by the AHCIP claim processing system based on pre-stored information.

Functional centre

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

General hospital

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

Good faith policy

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

Governing organization

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

Health service code

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

Health service provider

A licensed individual providing health services.

H-Link

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

Locum period

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

Locum tenens

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

Medical reciprocal program

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

Modifier code

(See **Fee modifier code**.)

Nursing home

A facility designated for the provision of nursing home care.

Opting in

Participating in the publicly funded health care insurance plan.

Opting out

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

Out-of-Country Health Services Committee

A prior approval committee that considers applications received from Alberta residents, their personal representative who is a resident of Alberta, or their physician/dentist for funding of insured medical, oral surgical and/or hospital services that are not available in Canada.

Paid at zero

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

PHN

Personal Health Number. The number assigned by Alberta Health 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*. Physicians are paid benefits according to an approved schedule of fees. Benefits may also be paid to eligible Alberta residents who are billed directly after receiving an insured service.

Practitioner

A licensed individual who provides health services.

Practitioner Identification Number (PRAC ID)

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

Provider

(See **Health service provider**.)

Recovery code

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

Registered physician enrolled

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

Registrant

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

Registration number

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

Resident of Alberta

A person who is legally entitled to be or to remain in Canada and makes his/her permanent home in Alberta. Does not include tourists, transients or visitors to Alberta. A resident is not entitled to coverage under the AHCIP if he/she is a member of the Canadian Armed Forces 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 Medical Benefits

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

Service provider

(See **Health service provider**.)

Service recipient

A person who receives health services (the patient).

Skill

A practitioner's ability or proficiency, such as a specialty or a certification, 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 physician and recognized by a licensing body.

Stakeholder

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

Statement of Account

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

Statement of Assessment

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

Statement of Benefits Paid

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

Submitter

(See **Accredited submitter**.)

ULI

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

Unlisted procedure

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

Varies

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

7.2 Health service codes that require supporting text/documentation

08.19AA	99.09A
08.19BB	99.09B
08.19CC	99.09C
08.19D	99.09D
08.19F	99.09E
08.19H	99.09F
08.19J	99.09G
08.19K	99.09H
	99.09J
13.99BA *	99.09K
13.99J	99.09L
13.99K	99.09M
	99.09N
21.14A	99.09P
28.49A	99.09Q
	99.09R
39.99A	99.09U
	99.09V
45.24	
	E500
51.49C	E500A
52.49A	E500B
52.49E	E552
98.03B	Y3
98.12P	
98.6 G	

* Refer to the Note in the Procedure List section of the Schedule of Medical Benefits for specific circumstances when supporting documentation/text is required for this health service code.

7.3 The Procedure List

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

To help you understand how the Procedure List works, please refer to the sample page that appears on the next page of this guide. 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 paper copy of the Procedure List is up to date as of the date indicated.
3. Roman numerals and description for the anatomical region, e.g., XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE.
4. This field is a heading used to identify body part and type of procedures.
5. The NOTE field contains special instructions for a health service code.
6. The health service code for the service performed.
7. A description of the health service code. In this example, it refers to removal or excision, first lesion.
8. BASE amount is the fee for the service, before application of any modifiers. This may be a dollar amount or the code BY ASSESS.
9. The ANE field indicates the anaesthetic fee for the service.
10. The letter V beside the base rate means the fee payable varies depending on the physician's skill and/or specific modifiers associated with the health service code.
11. BY ASSESS: The fee payable for this procedure depends on supporting information that must be submitted with the claim.

7.4 A sample page from the Procedure List

¹
Generated 2007/10/01

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

Page 179
²
As of 2007/10/01

³
XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

⁴ **98.1 Excision of skin and subcutaneous tissue (cont'd)**

	⁸ BASE		⁹ ANE
98.12G Laser treatment of cutaneous vascular tumors	64.68		100.00
98.12H Excision of soft tissue tumour(s) (subcutaneous) up to 30 minutes of operating time	73.01	V	100.00
⁵ NOTE: 1. For sebaceous cyst removal see 98.12C. 2. Each subsequent 15 minutes of operating time, or major portion thereof, may be claimed at the rate specified on the Price List; a maximum benefit applies.			
Warts or Keratoses			
NOTE: 1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrheic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum. 2. The treatment of common warts or keratoses is an uninsured service.			
⁶ 98.12J ⁷ Removal or excision, first lesion	23.59	V	100.00
NOTE: Maximums apply, refer to Price List.			
98.12K Removal by fulguration, first lesion	23.59	V	100.00
NOTE: Maximums apply, refer to Price List.			
98.12L Non-surgical treatment (cryotherapy, chemotherapy), warts or keratoses	19.95		
NOTE: May be claimed in addition to a visit or consultation.			
98.12M Removal of pigmented benign naevus, excluding face	33.28	V	100.00
98.12N Removal of pigmented benign naevus of the face	49.47	V	100.00
98.12P Removal of complicated naevi	¹¹ BY ASSESS		
Multiple dysplastic or localized carcinomatous lesions of the skin			
98.12Q Removal of (any method)	36.23	V	100.00
Example: Multiple dysplastic naevi syndrome Multiple basal cell			
NOTE: 1. For second and subsequent, refer to Price List. 2. Maximums apply, refer to Price List.			
98.12R Removal first plantar wart	38.70	V	100.00
NOTE: 1. For non-surgical treatment, see HSC 98.12L. 2. Maximums apply, refer to Price List.			
Condylomata acuminata			
98.12S Non surgical treatment, cryotherapy	24.44		

7.5 The Price List

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

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

1. Description: Warts or Keratoses is the section heading.
2. 98.12J is the health service code. See the Procedure List for a description of this code.
3. \$23.59 is the base fee for this procedure.
4. This field lists all modifier types that apply to this health service code. (98.12J has nine applicable modifier types.)
5. A listing of all modifier codes that affect payment, applicable to this health service code. For example:
 - A ROLE modifier code entered on a claim indicates the function performed by the physician in providing the service.
 - The modifier codes (1, 2-105) associated with modifier type ANU indicate the maximum number of services that may be claimed by a physician using role modifier ANEST. (Supporting text is required if this maximum is exceeded.)
6. The letter Y in this field identifies each explicit modifier. When applicable, these must be entered on a claim prior to submission.
7. This field shows what effect the modifier has on the base amount. Example: When role modifier ANE is entered on a claim for health service code 98.12J, the base amount is replaced by the amount in the next column.
8. This field indicates the fee for each modifier code. Example: The ANE fee for health service code 98.12J is \$100.00.
9. The category code for each health service code. For example, the letter M identifies the service as a minor procedure.

7.6 A sample page from the Price List

RG 120

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

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Generated 2007/10/01

As of 2007/10/01

HSC	BASE RATE	TYPE	CODE	EXPLCT	MODIFIER ACTION	AMOUNT	CAT
1 Warts or Keratoses							
2	3	4	5	6	7	8	9
98.12J	23.59	BMI	BMIANE	Y	Increase By	25%	M
		BMI	BMIANT	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	100.00	
		ROLE	ANEST	Y	Replace Base	16.00	
		ANU	ANU				
			1		For Each Call Pay Base At	100%	
			2-105		For Each Call Increase By	16.00	
		UGA	UGA	Y	Replace Base	125.90	
		CALL	NBRSER				
			1		For Each Call Pay Base At	100%	
			2-3		For Each Call Increase By	9.45	
			4-4		For Each Call Increase By	9.32	
			MAX			51.81	
		TRAY	MAJT		Increase By	32.12	
		NBTR	NBTR	Y			
		SURC	RDEV	Y	Increase By	23.70	
		SURC	RDNTAM	Y	Increase By	56.91	
		SURC	RDNTPM	Y	Increase By	56.91	
		SURC	RDWK	Y	Increase By	23.70	
		LVP	LVP75	Y	Reduce Base To	75%	
98.12K	23.59	BMI	BMIANE	Y	Increase By	25%	M
		BMI	BMIANT	Y	Increase By	25%	
		ROLE	ANE	Y	Replace Base	100.00	
		ROLE	ANEST	Y	Replace Base	16.00	
		ANU	ANU				
			1		For Each Call Pay Base At	100%	
			2-105		For Each Call Increase By	16.00	
		UGA	UGA	Y	Replace Base	125.90	
		CALL	NBRSER				
			1		For Each Call Pay Base At	100%	
			2-5		For Each Call Increase By	6.24	
			6-6		For Each Call Increase By	3.17	
			MAX			51.72	
		TRAY	MINT		Increase By	10.85	
		NBTR	NBTR	Y			
		LVP	LVP75	Y	Reduce Base To	75%	

7.7 Alberta Health and Wellness resources

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

- Schedule of Medical Benefits
- Physician's Resource Guide
- Bulletins
- Interactive voice response (IVR) system
- Statement of Assessment and Statement of Account

Physicians are encouraged to make these resources easily accessible for reference and use by their staff as well. This will enable physician 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 Schedule of Medical Benefits is updated periodically and posted on our website at www.health.alberta.ca/professionals/fees.html. Please check regularly to ensure you are using the most recent edition of the Schedule for your claim submissions. See the Introduction to this guide for more information.

7.7.1 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.

Assistance available:

Phone number:

Information about:

- Claim assessment or reassessments, including medical reciprocal claims
- General billing inquiries
- Maximum of three issues per call

780-422-1600 **
(8:15 a.m. – 4:30 p.m.)

Information about:

- Practitioner or facility registration
- Changes to address, skill, business arrangement
- Direct deposit, banking information

780-422-1522 **
(8:15 a.m. – 4:30 p.m.)

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
- Application support

780-644-7643 **
(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
- Ensure 15 business days have elapsed since the statement date before calling

780-415-8731
(24 hour access)
The public also uses this number to request other information.

General inquiries about AHCIP coverage and benefits

780-427-1432
(8:15 a.m. – 4:30 p.m.)
The public also uses this number to request information.

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

7.7.2 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

Email: health.practitionerinquiries@gov.ab.ca



Note: You can also report your business mailing address changes using the above email address.

7.7.3 Obtaining resource material from Alberta Health and Wellness

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

- Forms are located 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 Schedule of Medical Benefits, Diagnostic Code List, Explanatory Code List, Facility Listing and Physician's Resource Guide are located at www.health.alberta.ca/professionals/fees.html.
- Bulletins, which contain information about Schedule of Medical Benefits amendments and advice regarding claim submissions, clarification of assessment, etc., are produced as necessary and posted at www.health.alberta.ca/professionals/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.

7.8 Key legislation/regulations

Legislation/Regulation	Section(s)	Overview
<i>Alberta Health Care Insurance Act</i>		
	4(2)	All claims for benefits are subject to assessment and approval by the Minister. The amounts of benefits paid and to whom they are paid are determined in the regulations.
	6(1)(2)	The Alberta Health Care Insurance Plan (AHCIP) will only pay benefits for insured health services if the physician is opted into the AHCIP when the insured services were provided.
	6(3)	In the event of an emergency, the AHCIP may pay benefits to an opted-out physician. <i>(See section 10 below.)</i>
	9(1)	Physicians opted into the AHCIP cannot extra bill for services insured under the plan. <i>(See 11(1)(a)(b) below.)</i>
	9(2)(3)	Physicians opted into AHCIP who contravene the Act by extra billing for insured services can: <ul style="list-style-type: none"> • receive warning letters from the AHCIP; • have the contravention referred to the College of Physicians and Surgeons of Alberta; and/or • be subject to an order that opts the physician out of the AHCIP for a specified period of time.
	10	Physicians opted out of the AHCIP cannot extra bill for insured services provided in an emergency situation. <i>(See section 6(3) above.)</i>
	11(1)(a)(b)	Physicians opted into the AHCIP cannot charge or collect an additional fee as a condition of the patient receiving a service insured under the plan nor an amount for any good or service as a condition to receiving an insured service.

Legislation/Regulation	Section(s)	Overview
<i>Alberta Health Care Insurance Act</i>		
	11(2)	<p>Physicians can charge or collect a fee for the provision of an uninsured service or pharmaceuticals, in situations:</p> <ul style="list-style-type: none"> • where such a charge or collection is not otherwise prohibited under the <i>Alberta Health Care Insurance Act</i> or the <i>Hospitals Act</i>; and • where the physician reasonably determines the necessity of providing the uninsured service or pharmaceutical prior to providing a service insured under the AHCIP.
	11(3)(4)	<p>If a physician collects a fee in contravention of section 11(1), the Minister may recover the amount from a physician in a civil action and reimburse the person charged the amount.</p>
	12(1)(2)	<p>If an opted-in physician provides services insured under the AHCIP and knowingly extra bills for those services, the physician will not be paid for the insured services by the plan and may be subject to the actions set out in section 9(2) described above. (<i>See 9(1) above.</i>)</p>
	13(1) - (3)	<p>If a physician contravenes section 9, 10 or 12, the Minister has the right to recover benefits paid for insured services under the AHCIP and/or any additional amount the physician may have collected from a person for the insured services. In the latter case, the Minister can reimburse the person for the additional amount recovered from the physician.</p>
	14	<p>A physician contravening section 9, 10, 11 or 12 is liable to a fine of not more than \$10,000 for a first offence and \$20,000 for the second and each subsequent offence.</p>

Legislation/Regulation	Section(s)	Overview
<i>Alberta Health Care Insurance Act</i>		
	15(1)(2)	Prior to providing insured services, a physician opted out of the AHCIP is obligated to advise the patient of the opted-out status and that the patient is not entitled to reimbursement by the AHCIP for services provided by the physician. This provision is not applicable in situations where the opted-out physician is providing insured services in an emergency (section 6(3) and 10).
	16(a) - (q)	This section establishes the authority of the Lieutenant Governor in Council to make regulations pertaining to the insurability and provision of health services in Alberta.
	17(a) - (c)	This section establishes the Minister's authority to make regulations with respect to what goods and services are basic services and/or extended health services under the AHCIP, the benefit rates for those services, as well as the manner in which benefits are paid and to whom.
	18(1) - (8)	These sections establish and lay out the parameters of the Minister's authority to reassess physician claims paid under the AHCIP.
	19(1) - (5)	If a physician becomes liable under section 18(5) of the Act, this section establishes and sets out the parameters of the Minister's authority to pay no benefit or pay a reduced benefit on a reassessment of a claim paid under the AHCIP.
	39(1) - (4)	This section establishes and sets out some of the Minister's authority to examine and audit a physician's books, accounts and/or records (other than patient records) with respect to claims for or the payment of benefits for providing insured services under the AHCIP.

Legislation/Regulation	Section(s)	Overview
<i>Alberta Health Care Insurance Regulation</i>		
	12(2) (a) - (p)	This section sets out the services not considered basic health or extended health services under the AHCIP.
	13(1) - (6)	When benefits are paid or are payable for diagnostic imaging services provided to a patient, physicians are required, at the patient's request, to make the diagnostic images available to any other practitioner designated by the patient. This section sets out what is expected of the physician in this regard and lays out the actions the Minister may initiate should a physician not comply with the regulation.
	14(1)(2)	A physician cannot bill a resident or another government department or agency for the provision of insured services where the physician has submitted or intends to submit a claim to the AHCIP for the payment of benefits for the insured services provided. To do so is an offence.
	14(3)	Physicians cannot extra-bill insured services that have a maximum benefit limit.
	15(1)	Physicians are required to file information with the Minister pertaining to their training, the type of practice they are engaged in, and other related information.
	15(2)	Physicians must retain original documentation related to the provision of insured services for a period of not less than six years.

Legislation/Regulation	Section(s)	Overview
<i>Claims for Benefits Regulation</i>		
	3(1) - (5)	This section outlines to whom the Minister may pay benefits for health services provided.
	4(1)	“Clinic” is defined as a group of practitioners who practice their profession together.
	4(2)	This section sets out to whom a practitioner may assign the benefits to which he/she is entitled.
	4(3)	Practitioners are responsible for ensuring the accuracy of information provided on a claim.
	5(1) - (2)	These sections set out what is required of practitioners when claiming for insured services under the AHCIP.
	6	The Minister can adjust a claim paid in error.
	7(1) - (3)	These sections outline the time limits for the Minister paying claims.

Legislation/Regulation	Section(s)	Overview
<i>Medical Benefits Regulation</i>		
	3(1)	This section establishes that the benefits payable for insured medical services are set out in the Schedule of Medical Benefits.
	3(2)	Notwithstanding 3(1), unless otherwise approved by the Minister, benefits payable are limited to the lesser of the amount claimed and the rates established in the Schedule of Medical Benefits.
	6	This section sets out what is included in the amount paid for insured medical services.
	7	This section outlines that benefits are not payable to a physician for providing pathology or diagnostic imaging services unless the physician has been accredited to provide the service by the College of Physicians and Surgeons of Alberta.
	8	No benefit is payable for alteration of appearance surgery unless the Minister prior approves the surgery.
	9(1) - (2)	These sections set out the requirements that must be met before the AHCIP pays for services provided by specialists.
	10(1)(2)	Benefit rates payable for laboratory medicine and pathology are determined by the regional health authorities (RHAs) and are only payable when provided by RHA authorized persons.

Copies of the *Alberta Health Care Insurance Act* and regulations can be downloaded from the following websites:

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

Paper copies of legislation are also available from:

Alberta Queen's Printer Bookstore
Main Floor, Park Plaza
10611 - 98 Avenue NW
Edmonton AB T5K 2P7
Telephone: 780-427-4952
Fax: 780-452-0668

To telephone or fax toll-free from outside the Edmonton area, call 310-0000 and enter the area code and number when prompted.