Alberta
HEALTH AND WELLNESS

# Application for Submitter Role

**For offices use only**

Document I.D. Stickers

Finance and Health Plan Administration Division
Claims Branch
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Attention: Business Analyst
Divisional System Support

## Submitter

Submitter PHN _____
***Note: This PHN will be assigned the Submitter Role.**

Name _____

Mailing Address _____

_____

_____

_____

_____

Proposed
Commencement Date _____

Marketing Contact Name _____

Phone Number _____

Fax Number _____

Technical Contact Name _____

Phone Number _____

Fax Number _____

## Submitter Agreement

I (we) agree to conform fully to Allberta Health Accreditation Requirements and Specifications as amended from time to time.

Signature(s) _____ _____

Name(s) _____ _____

Date _____

## Accreditation Use Only

**For Alberta Health Use**

Date Request Received _____

Submitter Prefix Code _____

Date Accreditation Approved (Conditional) _____

☐ Accreditation Letter Attached

**For ISM Alberta Use**

Terminal ID _____

**Part 1 White – *Submit to Alberta Health,* Part 2 Yellow – *Applicant Copy***