



Submitter/Client Relationship for Electronic Claim Submission

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

Attention: Administrator
Professional Registries

For offices use only

Document I.D. Stickers

Office use only

Date Received		
Year	Month	Day

Business Arrangement Contract Holder

Name _____	Service Provider or BA Contract Holder PHN _____
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 Service Provider to a BA, no form is required.

Submitter

Name _____	Submitter Prefix Code _____
PHN Number _____	Proposed Submission Date _____

Service Provider Certification and Agreement

I (we) hereby authorize this Accredited Submitter to submit my (our) claims electronically on my (our) behalf. I (we) further certify that my (our) agreement with the Accredited Submitter, who is (are) party to this application, conforms fully to Alberta Health Accreditation Requirements and Specifications and the Alberta Health Care Insurance Act and Regulations and that I am (we are) fully responsible for the correctness and security of all information submitted to obtain payment of claims.

Signature(s) _____

Name(s) _____

Date _____

Submitter Certification and Agreement

I (we) hereby certify that my (our) agreement with the Service Provider(s), who is (are) party to this application, conforms fully to Alberta Health Accreditation Requirements and Specifications.

Signature(s) _____

Name(s) _____

Date _____

Part 1 – Submit to Alberta Health, Part 2 – Accredited Submitter Copy, Part 3 – Service Provider Copy