Alberta
HEALTH AND WELLNESS

Professional and Facility Registries
10025 Jasper Ave NW
Box 1360 Station Main
Edmonton AB T5J 2N3

For office use only

Practitioner Information

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

Section A - New Practitioner Registration

Register me as a ☐ Practitioner ☐ Referral Practitioner ☐ also Register my Professional Corporation

Section B - Identification

Have you ever been registered with Alberta Health and Wellness as a service recipient or practitioner? ☐ Yes ☐ No

If yes, provide your Personal Health Number _ _ _ _ _ – _ _ _ _

If no, provide your Out of province health number *(if applicable)* _ _ _ _ _ _ _ _ _ _ Province _ _

Surname	First Name	Middle Name

Gender ☐ Male ☐ Female | Date of Birth Year _ _ _ _ Month _ _ Day _ _

Business Mailing Address		Residence Mailing Address	
City	Province	City	Province
Country	Postal code	Country	Postal code
Phone Area Code ( )		Phone Area Code ( )	
Fax Area Code ( )		Fax Area Code ( )	

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

Section C - Organization Information

Organization Name

Business Mailing Address
☐ Same as Business Mailing Address in **Section B** or

City	Province	Country	Postal Code

Phone Area Code ( ) | Fax Area Code ( )

A copy of your licence or letter from your licensing body must be attached. Special licence physicians must attach a copy of the Certificate of Agreement and Undertaking outlining the terms and conditions.

Section D - Education, Professional Association Registration and Specialties/Certifications

Degree Granted	Graduation Date (Year Month Day)	Institution Name	Province/ State	Country

College or Association registered with ______

Date Registered (Year Month Day) ______ Licence Number ______

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

______ Year Month Day ______

______ Year Month Day ______

Section E - Business Arrangement (BA) Information (See Glossary)

BA Effective Date (Year Month Day) ______ ☐ Fee for Service ☐ Locum – Medical only ☐ Alternate Payment Plan (APP)

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 P.C./Clinic or Name ______

Identifier ______

Send Statement of Assessment and Statement of Account to ☐ Me or ☐ My P.C./Clinic or Name ______

Identifier ______

The Accredited Submitter for this BA is *(name)* ______

If you have more than one specialty, 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 ______ – ______

If you have more than one specialty, 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."

______ Service Provider Signature ______ Phone Number

______ BA Contract Holder Signature/APP Authorized Representative Signature ______ Phone Number

______ BA Contract Holder Name and Position/Title/APP 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	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.)

☐ Examination Room (Practitioner's Office)
☐ Clinical Lab*
☐ Diagnostic Imaging*
☐ Non-Hospital Surgical Suite*
☐ Other Diagnostic Lab*
☐ Radiology Oncology*
☐ Electrodiagnosis*

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

Practitioner's signature ____________________ Date ____________________

Return completed forms to Professional and Facility Registries at the address on page 1, or fax to (780) 422-3552. If you have any questions, call (780) 422-1522, or toll free in Alberta via 310-0000.

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 require further information, contact Professional and Facility Registries.

Glossary of Terms

Accredited Submitter: An organization or individual accredited by Alberta Health and Wellness (AHW) to transmit electronic claims and retrieve results of transactions for practitioners.

Alternate Payment Plan: A mechanism to remunerate health service providers in a manner other than the traditional fee-for-service method.

Business Arrangement: An agreement with AHW to establish the arrangement for the payment of health services provided. All practitioners registered with AHW 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 the business arrangement with AHW.

Statement of Account: A statement outlining the amount that AHW 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 that details the assessment result of each claim submitted. Claims reduced, refused, or paid at zero will have an explanatory code.