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

For office use only

Alternate Payment Plan (APP) Request

Note: To register an Alternate Payment Plan, a copy of the list of participating physicians must be attached.

Section A - Identification and Type of APP

APP Program Name _____

APP Program type ☐ Block ☐ Formal Capitation ☐ Geographic Capitation ☐ Contractual ☐ Sessional**

Effective date: from Year Month Day to Year Month Day

**** Note:** If APP program type is Sessional and payment is to be made to the individual participating physicians, form AHC 917 must also be completed.

Section B - Organization Information

Site Name (if different from APP name) *(please print)*		
Business Mailing Address *(please print)*		
City	Province	Postal Code

Section C - Request for APP Business Arrangement

Direct Deposit to

☐ Chequing – attach a void cheque

or

☐ Savings – attach documentation from financial institution indicating Bank, Branch Transit, and Account Number

Send Statement of Assessment and Statement of Account to

Name _____

Identifier

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

Suppress Statement of Assessment production ☐ Yes ☐ No

(If your accredited submitter provides this information, it may not be necessary to receive it from Alberta Health and Wellness)

Section D - Signatures of Participating Physicians (This section must be completed before this form is considered valid. **Exception: ***Do not*** complete this section if APP program type is Sessional ***and*** payment is to be made to the individual participating physicians. See note in Section A.)

"I, the Practitioner, assign to the APP 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 Arrangement. 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."

Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_
Physician Signature _____	Practitioner Identifier	_

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

Authorized Representative Full Name *(please print)*	Signature	
Position *(please print)*	Date	Phone Number

Return completed forms to Professional and Facility Registries at the address on page 1, 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 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.