



Business Arrangement and Relationships Application

Alberta Health Care Insurance Plan

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of enrolling you for programs or benefits funded by Alberta Health. 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 any questions regarding the collection or use of this information, please contact an Alberta Health representative toll-free within Alberta at 310-000 then 780-422-1522 or by mail at Alberta Health, Claims Management Unit, PO Box 1360 Stn Main, Edmonton, AB T5J 2N3

For AH Office Use Only

Important: Alberta Health must be notified when you move

Type of Request

Registration Type

Submitter/Client

Comments as applicable

Identification of the Business Arrangement (BA) Contract Holder

Practitioner Identifier

BA Contract Holder ULI

Business Arrangement Number (if known)

Practitioner Last Name

Legal First Name

Middle Name

BA Contract Holder Name

Contact Name

Business Phone

Business Fax

Email Address

Business Mailing Address

City or Town

Province

Postal Code

Yes, change my business mailing address to that above

Business Arrangement (BA) Contract Holder Certification and Agreement

I, the BA contract holder, authorize the accredited submitter identified below to submit my claims electronically to Alberta Health on my behalf. I certify that my agreement with the Practitioner, who is a party to this application, conforms fully with the Electronic Claims Submission Specifications Manual, the *Alberta Health Care Insurance Act* and regulations, and the *Health Information Act* and regulations and that I am fully responsible for the correctness and security of all information submitted to obtain payment of claims for health services.

Contact Number

Name

Date yyyy-mm-dd

BA Contract Holder Signature

Accredited Submitter Certification and Agreement - Must be completed for the form to be valid.

"I, the accredited submitter, certify that my agreement with the BA contract holder, who is a party to this application, conforms fully with the Electronic Claims Submission Specifications Manual, the *Alberta Health Care Insurance Act* and regulations, and the *Health Information Act* and regulations."

Submitter ULI

Submitter Prefix Code

47595-3561

CPI

Contact Number

Name

Date yyyy-mm-dd

Accredited Submitter Signature

888-686-8560

CloudPractice Inc

Send completed forms to the Provider Relationship & Claims Unit via **Fax** 780-422-3552, or **Email** Health.PracForms@gov.ab.ca

If you need assistance completing this form, please refer to the completion instructions, or call 780-422-1522 in Edmonton / toll-free at 310-0000, then 780-422-1522.