Alberta
HEALTH AND WELLNESS

Submitter/Client Relationship for Electronic Claim Submission

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: Administrator
Professional Registries

Office use only

Date Received
Year Month Day

Business Arrangement Contract Holder

Name _____

Business Address _____

_____

_____

_____

Service Provider or
BA Contract Holder PHN _____

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 Logic Resources

PHN Number _____

Submitter Prefix Code LOG

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***