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

Business Arrangement Request

Comments *as applicable*

Identification of the Business Arrangement (BA) Contract Holder

◯ Practitioner ◯ Professional Corporation (PC) ◯ Clinic

Practitioner Identifier | PC/Clinic Name

Practitioner Last Name | Legal First Name | Middle 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

Create, Change, or End Business Arrangement (BA) - Provide the information on the BA being created or modified.

☒ Assign a new BA

☐ Change BA effective date

☐ Change my BA default skill code

☐ End my relationship with the BA

☐ Change where my statements are sent

◉ Fee for Service ◯ Locum ◯ Alternate Relationship Plan (ARP) ◯ Academic medicine and Health Services Program (AMHSP)

Effective Date yyyy-mm-dd | Skill that will be used on most claims

Business Arrangement (BA) Information - Provide details for the BA

For Direct Deposit Attached is:

◯ a **void cheque**

◯ documentation **from a financial institution** indicating bank, branch transit, and account number.

Make Payment to

Practitioner Last Name:	Legal First Name:	Middle Name:

Send Statement of Account to

Send Statement of Assessment to

Business Arrangement (BA) Contract Holder Certification and Agreement - Must be completed if the Contract Holder is not the Practitioner signing this form.

I, the BA contract holder, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number	Name	Date yyyy-mm-dd	BA Contract Holder Signature

Accredited Submitter Certification and Agreement

"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		

Practitioner Authorization

I, the Practitioner, certify, to the best of my knowledge, that the information provided in this form is true and correct.

Contact Number	Name	Date yyyy-mm-dd	Practitioner Signature

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.