ARP0006 Alternate Relationship Plan Request Completion Instructions

General information

Completion of the ARP006 Alternate Relationship Plan Request Form will enable the creation and setup of the ARP Program, including the program business arrangement and the participating physicians.

Form completion

The form will expand and display specific sections depending on the selections made. Adobe Reader is needed to properly use the form. Some browsers don't use Adobe Reader, so ensure you first download the form and then open it with Adobe Reader.

Section A – Identification and Type of ARP

1. Enter the ARP Program Name and ARP Program Type exactly as shown in the Ministerial Order (clinical) or Grant Agreement (academic). The following choices are available: APCO Annualized, APSE Sessional, APCA Capitation – Blended, Other (please specify).
2. Enter the ARP Effective Date and ARP Contract End Date exactly as shown in the Ministerial Order (clinical) or Grant Agreement (academic).
3. Enter the ARP Payment Frequency. The following choices are available:
   a. MNTH Monthly – primarily used for Annualized ARPs
   b. SMTH Semi-Monthly – primarily used for Capitation – Blended ARPs
   c. THUR Weekly Schedule (Thursdays) – primarily used for Sessional ARPs
   d. Other (please specify)
4. Enter the ARP City where the Program office is located.

Section B – ARP Business Mailing Address

- Provide the complete business mailing address for the ARP program. The business mailing address may be used for all correspondence from Alberta Health, including claim statements.

Note: Alberta Health must be notified in advance of any changes to business mailing addresses by faxing a letter signed by the Authorized Representative (including the authorized representative practitioner identifier) to 780-422-3552.

Section C – Request for ARP Business Arrangement

1. Specify the Direct Deposit directions for payment to the ARP program business arrangement. A void cheque must be provided if direct deposit is to a chequing account. Bank details indicating the bank, branch transit, and account number must be provided if direct deposit is to a savings account.
2. Provide the Accredited Submitter Prefix – this is a three-letter prefix, i.e., XYZ.

3. The Statement of Assessment can be sent to one of three addresses:
   a. ARP Business Address stated in Section B
   b. Mailing address of the Accredited Submitter
   c. Mailing address of an Alberta Health Services (AHS) organization. The AHS organization ULI must be provided, i.e., NNNNN-NNNN.
4. The Statement of Account can be sent to one of three addresses:
   a. ARP Business Address stated in Section B
   b. Mailing address of the Accredited Submitter
   c. Mailing address of an Alberta Health Services organization. The AHS organization ULI must be provided, i.e., NNNNN-NNNN.
5. Indicate if you would NOT like to receive a copy of the Statement of Account (Yes) or if you would like to receive a copy of the Statement of Account (No).

Section D – Signatures of Participating Physicians

This section of the form will expand depending on the number of participating physicians.

- For each participating physician, provide the Practitioner Identifier, i.e., NNNN-NNNNN, indicate the Physician's Skill and attach a corresponding Letter of Participation (LOP).
- Once the form is completed, it must be printed and a Signature is required from each participating physician.
- If you have more than 15 physicians practicing within the ARP, please attach LOPs to the form of those who have not signed the form.

Section E – Authorization

1. Enter the Authorized Representative Full Name, Position, Practitioner Identifier, i.e., NNNN-NNNNN, and Telephone Number.
2. Enter the date the form was completed.
3. Once the form is completed, it must be printed and a signature is required from the authorized representative.

Print and save

- A copy of the form with the completed fields can be saved at any time.
- The form cannot be printed until all the required fields are completed. Once printed, a signature is required from each participating physician and a signature is required from the authorized representative.

Submission

Submit completed forms to:

- Alberta Health, Alternative Compensation Delivery Unit:
  - Per the address listed in the form
  - Fax: 780-422-5208
  - Scan and email signed forms to your Policy Analyst

Contact information

Alternative Compensation Delivery Unit:

- Phone: 780-427-3677
- Toll free in Alberta: 310-0000, then 780-427-3677

Additional information

For more information, go to: http://www.health.alberta.ca/professionals/ARP-Clinical.html

