Ontario

Ministry of Health

Clear Form

Provider Number

Ministry use

Reciprocal Claim

Confidential when completed

Province	Registration Number	Date of Birth (year / month / day)	Account Number	Payment Prog.	Payee

Referring Provider Number	Master Number	Inpatient Admission (year / month / day)	Patient's Surname	Patient's First Name	Sex

Service Code	Fee Submitted	No. of Services	Service Date yyyy mm dd	Diagnostic Code	Service Code	Fee Submitted	No. of Services	Service Date yyyy mm dd	Diagnostic Code

4421-84 (2020/03) 7530-5655

fold here

For Ministry Use Only

- ☐ Registration No. / Prov. Code missing/incorrect
- ☐ Date of Birth missing/incorrect
- ☐ Payment Program is missing/invalid
- ☐ Payee is missing/incorrect
- ☐ Please resubmit as Health Claim

Missing/Incorrect Service

- ☐ Referring Provider No.
- ☐ Master Number
- ☐ Admission Date
- ☐ Service Code
- ☐ Fee
- ☐ Number of Services
- ☐ Service Date
- ☐ Diagnostic Code
- ☐ Missing/Incorrect information as highlighted on claim card

Date	Station

Please detach here and return the top portion to the ministry. The bottom portion is a copy for your records.

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Service Code | Fee Submitted | No. of Services | Service Date yyyy mm dd | Diagnostic Code | Service Code | Fee Submitted | No. of Services | Service Date yyyy mm dd | Diagnostic Code

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Print Form

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