Ontario Ministry of Health

Completion Instructions for the Request for Prior Approval for Full Payment of Insured Out-of-Province (OOP) Health Services (in another province/territory)

Introduction

Unless specifically noted, all sections of this form must be fully completed and legible.

The form is required to request prior approval for full payment by the ministry for insured **OOP hospital/physician services** on behalf of a patient. The ministry does not cover transportation or accommodation costs associated with traveling for treatment.

Note: **OHIP does not pay for extended health services (e.g., home care, devices, etc.), ambulance services, transportation costs, or out-of-hospital food, accommodation, drugs or prescriptions including take-home prescriptions.**

Information about the OOP prior approval program and application forms are available on the ministry's website at: www.health.gov.on.ca/en/public/programs/ohip/outofprovince/priorapproval.aspx

These forms are available in a **fill and print** format or can be downloaded for completion. Completed forms may be sent to the ministry by fax: 613 536-3181 or 1 866 221-3536.

Physician Responsibilities

By signing the application, you, as the attending or treating physician, are prescribing a treatment based on your professional knowledge and assessment of the patient.

Do Not Complete This Form If:

- Treatment is required as a result of a work-related accident. Please complete a Health Professional's Report (Form 8) and contact the Workplace Safety and Insurance Board (WSIB) at www.wsib.on.ca to discuss coverage. OHIP does not insure service(s) to which a person is entitled under the *Workplace Safety and Insurance Act*.
- You are requesting Diagnostic Laboratory Testing. If these services are required, please complete the "Request for Prior Approval for Full Payment of Insured OOC Health Services for Diagnostic Laboratory Testing Form 4521-84. Note that this form can also be used for OOP Laboratory testing.

Full payment of medically necessary hospital and/or physician services will be authorized only when the proposed OOP service is:

- insured in Ontario;
- medically necessary and generally accepted in Ontario as appropriate for a person in these medical circumstances;
- not experimental in Ontario, not for research and not for a survey; and
- performed at a publicly funded hospital (that can bill reciprocally) or a facility with which the Minister of Health and Long-Term Care has entered into a preferred provider arrangement.

Please ensure that all sections of the form are legible; otherwise, it will be returned by fax asking for clarification of the information.

If you require clarification or additional information in order to complete this application form, please call the ministry's toll-free number 1 888 359-8807, or send an e-mail inquiry to: OHIPServicesOutsideOntario@ontario.ca

Instructions For Completing Form

Part 1 - Patient Information

The patient's health number and address must be current and correct (e.g., they must match the information on the ministry's database) or the application will be returned.

If the patient is under the age of 16, the parent or legal guardian must sign on the patient's behalf.

If the application is signed on behalf of a person over the age of 16 who is not the applicant, documentation must be provided which establishes that the person signing the form is legally authorized to do so. Acceptable documentation includes, for example, Power of Attorney for property or personal care.

Part 2 - Referring Ontario Physician

Note: This section is to be completed ONLY if an Ontario physician is involved in the application process.

Please provide the name, OHIP billing number, office address, office fax, email address and daytime telephone number of the Ontario physician. If the office telephone does not accept messages, please provide an alternate number.

Part 3 - Proposed OOP Facility/Hospital and Physician

Please provide the name and address of the OOP treatment facility and the name and details of the physician performing the proposed treatment. Please provide the reciprocal billing facility number for the hospital.

Part 4 - Treatment - General Information

This section must be fully completed and must include the clinical diagnosis in full and the proposed treatment or procedure for which prior approval is requested. Provide as much information to support the request in order to assist with the evaluation of the application including the patient's relevant medical records/referral letters, etc. (attach as separate documents). If services will be required on an inpatient basis, please provide the anticipated number of days and the planned admission date, if known.

If the patient is being referred OOP for an extended period of time, provide the reasons for the lengthy admission.

Note the following:

- If the request is for **bariatric surgery**, the patient must be recommended for the surgery by a multidisciplinary team at an Ontario Regional Assessment and Treatment Centre (RATC). Please ensure the assessment/recommendation from the RATC accompanies the application.
- If the request is for **cancer services**, please attach copies of all relevant documents including consultation letters. Additional information may also be requested.

Part 5 - Follow-up Care

Completion of this section is required to confirm the patient's follow-up care.

Part 6 - Signatures

This application must be signed and dated by both the patient (or the patient's authorized representative) and either the referring Ontario physician or OOP physician. If this application has not been signed by the patient, please explain why.

A decision letter will be sent to the signing physician and the applicant. A copy will be sent to the Ontario physician if applicable.

Ontario

Ministry of Health

For Ministry Use Only

Reference Number

Date Received (yyyy/mm/dd)

Request for Prior Approval for Full Payment of Insured Out-of-Province (OOP) Health Services (in another province/territory)

Either the attending OOP Physician or the attending Ontario physician must complete the entire form. Print clearly to ensure form is legible.

Is the OOP treatment required as a result of a work-related accident? ☐ Yes ☐ No

If yes, **do not** complete this form. Please complete a Health Professional's Report (Form 8) and contact the Workplace Safety and Insurance Board (WSIB).

Please Return to: Health Services Branch, Out of Country Prior Approval Program, 49 Place D'Armes, PO Box 48, Kingston ON K7L 5J3

Please Fax to: Program Manager, Out of Country Prior Approval Program at 613 536-3181 or 1 866 221-3536. For information or clarification regarding this form, please call 1 888 359-8807.

Part 1 - Patient

Last Name	First Name	Initials

Date of Birth (yyyy/mm/dd)	Sex ☐ Male ☐ Female	Health Number	Version

Current Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number (Home)	Telephone Number (Business/Daytime) ext.

Parent/Legal Guardian's Last Name (if applicable)	Parent/Legal Guardian's First Name (if applicable)

Where this form is signed by a person who is not the applicant, indicate the relationship between the applicant and the person completing the form:

☐ parent of child under 16 years of age ☐ legal guardian ☐ attorney under power of attorney

☐ other (specify) ►

If legal guardian, attorney or other, please provide copy of document which establishes that status or provide a consent signed by the patient permitting you to apply and communicate with the ministry on behalf of the patient if form is signed on behalf of person over the age of 16.

Part 2 - Referring Ontario Physician (if applicable)

Last Name	First Name	Provider Billing No.

Office Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number where we can reach you ext.	Fax Number	Email Address

Part 3 - Proposed OOP Health Facility/Hospital and Physician

Facility	Reciprocal Hospital No.

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

OOP Physician's Last Name	OOP Physician's First Name

Telephone Number ext.	Fax Number	Email Address

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Part 4 - Treatment - General Information

Clinical Diagnosis (condition for which treatment is sought)	Diagnostic Code

Please check whether the application is for:

☐ Inpatient Services ☐ Outpatient Services

No. of days anticipated for hospitalization	Provide anticipated admission date (yyyy/mm/dd)	Provide anticipated date of surgery (yyyy/mm/dd)

Proposed treatment and/or procedure for which prior approval is requested (See Part 4 of Instructions)

Is this treatment generally accepted in Ontario as appropriate for a person in these medical circumstances?

☐ Yes ☐ No ☐ Unknown

Is this treatment generally accepted as experimental in Ontario?

☐ Yes ☐ No ☐ Unknown

Is this treatment medically necessary for a person in these medical circumstances?

☐ Yes ☐ No ☐ Unknown

Part 5 - Follow-Up Care

For patients requiring ongoing long-term care, please provide details relative to the short and long-term plans for follow up care

Part 6 - Signatures

All accompanying documents will be considered as part of this application. I understand that the Ministry of Health (MOH) or its agents may collect, use or disclose personal health information and/or records relating to this application for the purposes of the administration of the *Health Insurance Act* including the administration of the OOP program. I understand that this may involve disclosure of personal health information and/or records related to any health care providers, institutions and agencies that require it as determined necessary by OHIP.

It is an offence to knowingly give false information to the Ontario Health Insurance Plan in any application or statement made to the plan.

Name of Patient or Parent/Guardian	Signature of Patient or Parent/Guardian	Date (yyyy/mm/dd)
Relationship to Patient (if not signed by patient)	Please explain why form has not been signed by patient	

I hereby declare the information provided by me to be true.

Signature of ☐ Ontario Physician or ☐ OOP Physician (please check one) Date (yyyy/mm/dd)

Print Form Clear Form

