Completion Instructions for Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services - Emergency/911/CritiCall Transfers

You must contact CritiCall at 1 800 668-4357 for Emergency OOC Treatment.

IF YOUR PATIENT REQUIRES AN EMERGENCY TRANSFER, PLEASE CONTACT CRITICALL TO ARRANGE: 1 800 668-4357.

FAX COMPLETED FORM TO CRITICALL: 905 388-6377.

INTRODUCTION

All sections of this form must be fully completed and legible.

The form is required to request approval for full payment by the ministry for insured **OOC hospital/medical services** on behalf of your patient. The ministry does not cover travel and accommodation costs associated with traveling OOC for prior approved treatment.

Information about the OOC prior approval program and application forms are available on the ministry's website at: **www.ontario.ca/outofcountry**

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 Ontario doctor, are prescribing a treatment based on your professional knowledge.

DO NOT COMPLETE THIS FORM IF:

- You do not know the answer to the questions in Part 4. In most cases, you will have to research the availability of current services in Ontario and wait times in several areas of the province.
- You are requesting medical treatment/health services such as cancer treatment, bariatric surgery, etc. If these services are required, please complete the Request for Prior Approval for Full Payment of Insured OOC Health Services Form 4520-84.
- 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.

Full payment of medically necessary hospital/medical services will be authorized only when the proposed OOC treatment or procedure is:

- performed at a hospital or licensed health facility; and
- not experimental or for research or for a survey; and
- generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person; and
- either not performed in Ontario by an identical or equivalent service; or
- performed in Ontario but the insured person must receive the services outside Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.

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**

Part 1 – Patient Information

When completing this section, the Ontario physician's office should verify that the patient's health number and address are current and correct.
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.

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Part 2 – Referring Ontario Physician

Please advise if you are the patient's primary care physician. Please also provide your name, OHIP billing number, office address and the name of the Ontario hospital. You are also required to provide a telephone number where the ministry can reach you. If your office telephone does not accept messages, please provide an alternate number such as your private line.

Part 3 – Proposed OOC Health Facility/Hospital

You must contact CritiCall to arrange for your patient's transfer. CritiCall will provide the referring Ontario physician with the name of the U.S. facility to be included on the form. A preferred provider must be selected if a preferred provider arrangement has been established for the required service. For a list of preferred provider facilities, please visit the ministry's website at: **http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry.aspx**

Part 4 – Treatment/Service Requested

This section must be fully completed and must include the clinical diagnosis, the proposed treatment being requested OOC and the name of the Ontario physician who will be providing follow up care in Ontario.

This section establishes the need for the patient to be referred outside Canada and all criteria described in the *Health Insurance Act* must be met for the application to be approved.

The first two questions establish whether the treatment being requested is appropriate for a person in the same medical circumstances as the patient and whether the service is performed in Ontario by an identical or equivalent procedure.

The next two questions establish whether the treatment must be performed OOC to avoid a delay which would result in death or medically significant irreversible tissue damage. At least one of these questions must be answered "yes". A "no" answer to each of these questions indicates that there is no urgent need for the patient to go OOC for treatment.

It is expected that the referring Ontario physician will have attempted to find treatment for his/her patient in Ontario and will provide the names of all health professionals contacted in this regard. There are no geographical limitations described in the *Health Insurance Act* relating to the travel distance required to obtain treatment in Ontario.

Part 5 – Follow-up Care

Completion of this section is required to confirm that the patient's follow-up care will be provided in Ontario and not by the OOC physician.

Signatures

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

Ontario Ministry of Health

Ontario Ministry of Health

For Ministry use only

Reference Number

Date rec'd — Year / Month / Day

Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services

Emergency/911/CritiCall Transfers

Was this a CritiCall Transfer? ☐ Yes ☐ No

You must contact CritiCall at 1 800 668-4357 for Emergency OOC Treatment. Fax completed form to 905 388-6377.

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

If yes, complete this form in addition to a Health Professional's Report (Form 8) and contact the *Workplace Safety and Insurance Board (WSIB).*

AN ATTENDING ONTARIO PHYSICIAN MUST COMPLETE THE ENTIRE FORM. PRINT CLEARLY TO ENSURE FORM IS LEGIBLE.

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

Applications may be faxed to 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 (Year / Month / Day) | Sex ☐ Male ☐ Female | Health Number | Version Code

Current Mailing Address *(Street number and name, R.R., P.O. Box, General delivery)*

City | Province | Postal Code

Telephone Number *(Home)* ( ) — | Telephone Number *(Business/Daytime)* ( ) — | Extension

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

Are you the patient's primary care physician? ☐ Yes ☐ No

Last Name | First Name

Name of Hospital

Office Address *(Street number and name, R.R., P.O. Box, General delivery)*

City | Province | Postal Code | Provider Billing Number

Telephone Number where we can reach you ( ) — | Extension | Fax Number ( ) —

Email Address *(optional)*

Part 3 - Proposed OOC Health Facility/Hospital

Facility *(A preferred provider must be selected if a preferred provider arrangement has been established for the required service).*

Address *(Street number and name, R.R., P.O. Box, General delivery)*

City | State/Country | Code

Name of: ☐ OOC physician ☐ Contact person | Last Name | First Name

Telephone Number ( ) — | Extension | Fax Number ( ) —

Email Address

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Part 4 - Treatment / Service Requested

Clinical Diagnosis *(condition for which treatment is sought)*:

Diagnostic Code

Proposed treatment and/or procedure for which approval is requested:

Name of the Ontario Physician who will be providing ongoing follow-up care in Ontario:

Is this treatment generally accepted **in Ontario as appropriate** for a person in these medical circumstances? ☐ Yes ☐ No

Is this treatment performed in Ontario by an identical or equivalent procedure? ☐ Yes ☐ No

If "yes", where is this service performed in Ontario? ______

If "no", please explain why? ______

Is this treatment required out of Canada to avoid a delay in obtaining the treatment in Ontario that would:

A) Result in death? ☐ Yes ☐ No B) Result in medically significant irreversible tissue damage? ☐ Yes ☐ No

If "yes" to either of the above, how soon is the treatment required?

If tissue damage is reasonably expected to result from delay, describe the type of damage:

If this request is for **cardiac care** treatment, provide the name of the person contacted at the CorHealth Ontario, 416 512-7472.

Part 5 - Follow-Up Care

For patients requiring ongoing long-term care, please provide details relative to your short and long-term plans for follow up care to be provided in Ontario should payment for out-of-country treatment be approved:

NOTE: *OHIP does not pay for ambulance services, transportation costs, or out-of-hospital food, accommodation, drugs or prescriptions, including take-home prescriptions.*

All accompanying documents will be considered as part of this application. I understand that the 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 OOC 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. Collection of any of this information is authorized by section 4.1 of the *Health Insurance Act.* For information about MOH collection practices, see our website at **www.ontario.ca/privacy-statement.**

PLEASE USE THIS FORM WHEN YOU ARE TRANSFERRING YOUR PATIENT *ON AN EMERGENCY BASIS* FROM AN ONTARIO HOSPITAL TO A U.S. HOSPITAL.

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 *(print or type)*	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 Referring Physician	Date *(yyyy/mm/dd)*