Completion Instructions for the Request for Prior Approval for Full Payment of Insured Out-of-Country (OOC) Health Services

INTRODUCTION

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 **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 Parts 5 and 6. In most cases, you will have to research the availability of current services in Ontario and wait times in several areas of the province.
- The required treatment has already been rendered as services will be ineligible for reimbursement.
- 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 Emergency/911/CritiCall Transfers. If these services are required, please complete the "Application for Approval of Full Payment of Insured OOC Health Services Emergency/911/CritiCall Transfers Form 4524-84.
- 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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English Form

Part 2 - Referring Ontario Physician
Please provide your name, OHIP billing number and office address. Please also 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
Please provide the name and address of the OOC treatment facility and the name of the physician or contact person at this facility. 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 - 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. 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 OOC for an extended period of time, the Ontario physician should also provide the reasons for the lengthy admission. You are also required to advise if this patient has made a previous attempt to receive this treatment OOC.

Part 4A - Bariatric Surgery - Treatment Requested
Patients must either be recommended for surgery by a multidisciplinary team at an Ontario Regional Assessment and Treatment Centre or participate in a multidisciplinary regimen of at least three months duration. If you are applying for bariatric surgery, please provide your patient's height, weight, co-morbidities and names of other Ontario health professionals consulted (attaching relevant consultation notes). Please advise if your patient suffers from any condition that could affect his or her suitability for surgery. Please also include the specific bariatric procedure being requested OOC as not all procedures are insured.

Parts 4B, 4C, or 4D - Request for Cancer Treatment/Inpatient Residential Treatment/Surgical Procedure
Please complete ONLY the section relating to the OOC service requested, i.e., OOC cancer treatment OR inpatient residential treatment OR a surgical procedure. Please provide all information requested.

Part 4E - MRI (Magnetic Resonance Imaging) Requested
Please specify the MRI procedure being requested. If you are applying for an open MRI please also explain why your patient requires this service and include your patient's height, weight and abdominal girth.

Part 5 - Treatment Availability
This section establishes the need for the patient to be referred outside Canada and all criteria described in the *Health Insurance Act* and Regulations must be met for the application to be eligible for approval.

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 6 - 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 the patient's 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)

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

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

Clear Form | Instructions

☐ **Cancer Treatment** ☐ **Surgical Procedure** ☐ **Bariatric Surgery** ☐ **Inpatient Residential Treatment**
☐ **Other Services (MRI, CT, Consultation)** *(specify)* _____

Is the OOC 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.
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

Last Name | First Name

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

  Disponible en français

Part 4 - Treatment - General Information

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

Please (✓) **whether the application is for:** ☐ Inpatient Services ☐ Outpatient Services

Has OOC treatment already been received without ministry approval? ☐ No ☐ Yes *(If yes, please provide date.)* Year Month Day

No. of days anticipated for hospitalization | Provide anticipated admission date Year Month Day | Date of OOC consultation *(if applicable)* Year Month Day | Date of surgery Year Month Day

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

Have you previously requested and/or obtained this service out of the country?
☐ No ☐ Yes Please advise the date and/or facility, city, state/country and provide reason for reapplication:

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

Part 4A - Bariatric Surgery - Treatment Requested

In addition to general information completed in Part 4 above:

Has your patient been assessed by an Ontario Bariatric Regional Assessment and Treatment Centre? ☐ Yes ☐ No If no, please arrange for your patient to be assessed in Ontario.

Specify bariatric procedure for which prior approval is requested *(Note: some bariatric procedures are not insured.)*

Patient's height: _____ ft _____ in. _____ cm | Patient's current weight: _____ lb _____ kg

Patient's co-morbid conditions *(attach copies of relevant documentation)*

Does your patient currently suffer from any condition *(such as depression or cardiovascular disease)* that could affect his or her suitability for surgery? Please explain.

Names of all other Ontario physicians (including specialists) consulted in the past 6-12 months concerning the co-morbid conditions listed above (attach list if necessary). **Please attach copies of all relevant documentation and consultation letters.**

Part 4B - Cancer Treatment Requested

In addition to general information completed in Part 4 above:

Please (✓) **whether the application is for:** ☐ Surgery ☐ Radiation ☐ Chemotherapy *(specify)*

Names of all other Ontario physicians (including specialists contacted at the nearest Regional Cancer Centre) consulted in the past 6-12 months concerning this condition listed above (attach list if necessary). **Please attach copies of all relevant documentation and consultation letters.**

Part 4C - Inpatient Residential Treatment Requested

In addition to general information completed in Part 4 above:

If this request is for **substance abuse** or **mental health** treatment, provide the name of the referral agent contacted at ConnexOntario, 1 866 531-2600.

If this request is for treatment of an **eating disorder,** provide the name of the referral agent contacted at ConnexOntario 1 866 531-2600 or the Provincial Network of Eating Disorder Service Providers in Ontario.

Names of all other Ontario physicians (including specialists) consulted in the past 6-12 months concerning this condition listed above (attach list if necessary). **Please attach copies of all relevant documentation and consultation letters.**

Part 4D - Surgical Procedure Requested

In addition to general information completed in Part 4 above:

Names of all other Ontario physicians (including specialists) consulted in the past 6-12 months concerning this condition listed above (attach list if necessary). **Please attach copies of all relevant documentation and consultation letters.**

Part 4E - MRI (Magnetic Resonance Imaging) Requested

Please (✓) **whether the application is:** ☐ with contrast ☐ without contrast ☐ with and without contrast

☐ open (explain why and provide the following information) _____

Patient's height: _____ ft _____ in. _____ cm Weight: _____ lb _____ kg Abdominal girth: _____ in. _____ cm

Part 5 - Treatment Availability

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?

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:

Name of physician(s) contacted to determine availability of treatment:	Estimated length of waiting period in Ontario: _____ Weeks / Months

If treatment is not available in Ontario:

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

Is this treatment generally accepted as **experimental in Ontario?** ☐ Yes ☐ No

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

Please provide details if this treatment is not performed in Ontario *(include names of physicians and/or health facilities contacted in Ontario to determine whether treatment is performed):*

Part 6 - 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: Written approval must be received from the ministry before OOC health services are rendered. *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.**

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)*

Print Form