Ontario

Ministry of Health and Long-Term Care

| For Ministry Use Only |
|---|
| Reference Number |
| Date Received (yyyy/mm/dd) |

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

**An attending Ontario physician must complete the entire form.**
**Print clearly to ensure form is legible.**

Is the OOC testing 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) 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*.

Please return to: Laboratories and Genetics Branch, Out of Country Program, 1075 Bay Street, 9th Floor, Toronto ON M7A 0A5.
Applications may be faxed to 416-326-2211 or 1-844-642-0202. For information or clarification regarding this form, please call 1-844-648-7944.

## 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

| 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 (optional) |
|---|---|---|
| | | |

## Part 3 - Proposed OOC Health Facility / Diagnostic Laboratory / Hospital

Facility
CENTOGENE

**Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | SCHILLINGALLEE 68 | |

| City/Town | State/Country | Postal Code |
|---|---|---|
| ROSTOCK | GERMANY | 18057 |

**Name of:** ☐ OOC physician ☐ Contact person

| Last Name | First Name |
|---|---|
| UEKERT (CHRISTINE.UEKERT@CENTOGENE.COM | CHRISTINE |

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| ext. | | SEELASTNAME@EMAIL.COM |

## Part 4 - Testing Requested

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

Reason service is required:

Please specify the laboratory test(s) required and attach a copy of the laboratory **requisition**:

Have you previously requested and/or obtained this service in Ontario?

☐ Yes (specify when and where) _____

☑ No (specify reasons) _____

Have you previously requested and/or obtained this service out of the country?

☐ Yes (specify when and where and provide reason for reapplication) _____

☑ No

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

☑ Yes ☐ No

Is this testing generally accepted as **research or experimental in Ontario?**

☐ Yes ☑ No

Is this testing performed in Ontario?

☐ Yes ☑ No

Is this a genetic test?

☑ Yes ☐ No

## Part 5 - Signatures

**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 MOHLTC 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 MOHLTC collection practices, see our website at http://www.health.gov.on.ca/english/public/legislation/bill_31/stat_info_practices.pdf.

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

Comments

| 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 Referring Physician | Date (yyyy/mm/dd) |
|---|---|
| | |