Ontario Ministry of Health and Long-Term Care

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

Instructions

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 diagnostic laboratory testing 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 http://www.health.gov.on.ca/english/providers/forms/form menus/ohip prof fm.html

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: 416-326-2211 or 1-844-642-0202**.

Physician Responsibilities

By signing the application, you, as the attending Ontario doctor, are recommending the requested testing 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.
- 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*.
- The required testing has already been rendered as services will be ineligible for reimbursement.
- 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 medical treatment/health services such as cancer treatment, bariatric surgery, MRI, etc. If these services are required, please complete the Request for Prior Approval for Full Payment of Insured OOC Health Services Form 4520-84.

Full payment of medically necessary therapeutic or diagnostic laboratory services will be authorized only when the proposed OOC service or procedure is:

- not experimental or for research or for a survey; and
- generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and
- not performed in Ontario.

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 **1-844-648-7944**, or send an e-mail inquiry to: Outofcountrylabsgenetics@ontario.ca

 © Queen's Printer for Ontario, 2017

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.

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/Diagnostic Laboratory/Hospital

Please provide the name and address of the OOC treatment facility and the name of the physician or contact person at this facility.

Part 4 - Testing Requested

This section must be fully completed and must include the clinical diagnosis in full and the reason the service is required. You are also required to advise if this patient has made a previous attempt to receive this treatment in Ontario and/or OOC.

Please specify test(s) requested and **attach a copy of the laboratory requisition**.

Applications received without a copy of the laboratory requisition will be considered incomplete and will not be processed until the necessary documentation has been provided.

Part 5 - 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 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
COUNSYL INC.

Address

Unit Number	Street Number	Street Name	PO Box
	180	KIMBALL WAY SOUTH	

City/Town	State/Country	Postal Code
SAN FRANCISCO	CALIFORNIA	94080

Name of: ☐ OOC physician ☐ Contact person

Last Name	First Name
ZEIBERG	MAX

Telephone Number	Fax Number	Email Address
888 268-6795 ext.	608 541-2450	BILLING@COUNSYL.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**:

COUNSYL FORESIGHT CARRIER SCREEN

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)