

<b>For Ministry Use Only</b>
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](http://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, 9<sup>th</sup> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Number		Version
<b>Current Mailing Address</b>				
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.
<b>Office Address</b>				
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 LifeLabs Genetics				
<b>Address</b>				
Unit Number	Street Number 7 455	Street Name 130th Street		PO Box
City/Town Surrey		State/Country British Columbia, Canada		Postal Code V3H 1H8

Name of:  OOC physician  Contact person

Last Name

Carter

First Name

Ron

Telephone Number

647-943-2797

ext.

Fax Number

647-943-2803

Email Address

Ask.Genetics@lifelabs.com

#### Part 4 - Testing Requested

Clinical Diagnosis (condition for which treatment is sought):

Diagnostic Code

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](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)