Ontario

Ministry of Health

# Application for OHIP Billing Number for Health Care Professionals

**Application Purpose:**

*This application is to be completed by health care professionals applying for an Ontario Health Insurance Plan (OHIP) billing number to submit claims to the Ministry of Health (the ministry) for insured services.*

**To apply for an OHIP billing number you must :**

1. Hold a valid Certificate of Registration with your governing body; and
2. Have an Ontario practice address; and
3. Complete and sign the **"Application for OHIP Billing Number for Health Care Professionals".**

**For more information on completing this application and/or applying for an OHIP billing number, contact CSB Connects by email: SSContactCentre.MOH@ontario.ca or by calling 1-800-262-6524.**

**Direct Bank Payment**

Monthly payments for your claim submissions will be issued electronically directly to your bank account. You must attach a scanned or original blank cheque with "VOID" written on it, from the financial institution where you bank, with the fully micro-encoded branch, institution and account numbers.

A cheque is not required if you are a health care professional joining a group(s) and you will only be providing services on behalf of the group.

***Note:** The ministry requires **30 days** advance notice in writing, of any changes to your banking arrangements or practice address(es).*

**To complete your registration, you must :**

- Complete all sections of the **"Application for OHIP Billing Number for Health Care Professionals";**
- Sign and date the application;
- Attach a scanned or original blank cheque with "VOID" written on it, **if applicable,** and
- Submit the application and blank voided cheque, if applicable, through ***one*** of the following options:

  Email: ProviderRegistration.MOH@ontario.ca

  Fax: 613-545-5848

  Mail: Ministry of Health
  Claims Services Branch
  Provider Registry Unit
  PO Box 68
  Kingston ON K7L 5K1

**Incomplete applications will be returned *WITHOUT* an OHIP billing number being issued.**

The ministry's collection of the personal information on this form is authorized under the *Health Insurance Act*, R.S.O. 1990, c. H.6, section 4.1, and Ontario Regulation 57/97. The information will be used to register you as a provider and to verify and monitor your eligibility for payment. It will also be used for health systems planning and coordination purposes. For information about this collection, contact the Director, Health Data Branch, Health System Information Management and Investment Division, Ministry of Health, 5700 Yonge Street, 4th Floor, Toronto ON M2M 4K5, by telephone: 1-866-803-0104 toll free and in Kingston, 613-548-4049 or by email: IMsupport@ontario.ca.



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# Application for OHIP Billing Number for Health Care Professionals

Language Preference: ☐ English ☐ French

## Section 1 – Personal Information

***Name*** *– Surname and given names must be consistent with the records from your issuing college.*

| Surname | Given Name(s) | Date of Birth | Sex |
|---|---|---|---|
| | | YYYY MM DD | ☐ M ☐ F |

**Have you received an OHIP billing number from the ministry before?**

☐ No ☐ Yes _____
Previous OHIP Billing Number

## Section 2 – Education Information

### Undergraduate Health Care Professional Training

| Type of degree/diploma | University where health profession degree/diploma achieved | Date of degree/diploma received |
|---|---|---|
| | | YYYY MM DD |

| City | Province/State | Country |
|---|---|---|
| | | |

### Postgraduate Health Care Professional Training – Specialty / Sub-Specialty Training *(if applicable)*

| University / Institution | City | Province/State | Country |
|---|---|---|---|
| | | | |

Discipline *(specialty)*

| Completion Date | Date Certified | |
|---|---|---|
| YYYY MM DD | YYYY MM DD | |

### Postgraduate Health Care Professional Training – Specialty / Sub-Specialty Training *(if applicable)*

| University / Institution | City | Province/State | Country |
|---|---|---|---|
| | | | |

Discipline *(specialty)*

| Completion Date | Date Certified | |
|---|---|---|
| YYYY MM DD | YYYY MM DD | |

## Section 3 – Certificate of Registration Information

*In order to obtain an OHIP billing number with the ministry, you must hold a valid licence with the governing body. If you hold an educational licence, you are not eligible to apply for an OHIP billing number at this time.*

### Ontario Certificate Information

| Indicate type of Current Certificate of Registration *(e.g. Independent Practice, restricted)* | Effective Date of Current Certificate | Current Registration Number issued by governing body |
|---|---|---|
| | YYYY MM DD | |

### Other Country / Province Information

| Indicate Country/Province of Certificate of Registration | Type of Certificate | Effective Date of Current Certificate | Current Registration Number issued by governing body |
|---|---|---|---|
| | | YYYY MM DD | |



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## Section 4 – Address Information

***Ontario Practice Addresses*** *(Note: PO box and R.R. numbers are not acceptable.)*

*List any additional addresses on a separate piece of paper. Proof of your practice at the address may be required. Practice addresses are not considered personal information and may be disclosed upon request. As such, it is recommended that your residential address not be provided.*

***Mandatory Practice Address Reporting*** *– Ontario Regulation 57/97 made under the Health Insurance Act requires that physicians provide, in writing, to the General Manager, an address for every place they regularly provide insured services to insured persons in Ontario. In addition to each address, it must be stated whether services are provided as a locum tenens and/or whether the only services provided are delegated procedures, as defined in the Schedule of Benefits, carried out under direct supervision of the physician. Provisions governing delegated procedures can be found in the General Preamble section of the Schedule of Benefits located at: http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/genpre.pdf*

*Where multiple addresses exist, please identify, where possible, which one is the primary practice site. You must give the ministry* ***at least 30 days*** *advance notice of any changes to your address information referred to below. Supporting documentation may be required to validate your address information provided.*

***Primary Practice Address*** – the site at which the majority of insured services is expected to be provided.

***Additional Site Address*** – any additional site at which insured services are expected to be provided.

**Primary Practice Address** *(check all applicable boxes)*

☐ Private Practice ☐ Group ☐ Hospital ☐ Locum ☐ Delegated Service ☐ Other *(e.g. employee)*

| Information Line *(e.g. c/o name, department of, to the attention of, floor)* | Start Date YYYY MM DD |
|---|---|
| Address *(apt. / suite, street no. & name)* | |

| City | Province | Country | Postal Code |
|---|---|---|---|
| | | | |

| Telephone Number ( ) | Ext. | Fax Number ( ) | Email Address |
|---|---|---|---|
| | | | |

**Additional Site Address** *(check all applicable boxes)*

☐ Private Practice ☐ Group ☐ Hospital ☐ Locum ☐ Delegated Service ☐ Other *(e.g. employee)*

| Information Line *(e.g. c/o name, department of, to the attention of, floor)* | Start Date YYYY MM DD |
|---|---|
| Address *(apt. / suite, street no. & name)* | |

| City | Province | Country | Postal Code |
|---|---|---|---|
| | | | |

| Telephone Number ( ) | Ext. | Fax Number ( ) | Email Address |
|---|---|---|---|
| | | | |

**Additional Site Address** *(check all applicable boxes)*

☐ Private Practice ☐ Group ☐ Hospital ☐ Locum ☐ Delegated Service ☐ Other *(e.g. employee)*

| Information Line *(e.g. c/o name, department of, to the attention of, floor)* | Start Date YYYY MM DD |
|---|---|
| Address *(apt. / suite, street no. & name)* | |

| City | Province | Country | Postal Code |
|---|---|---|---|
| | | | |

| Telephone Number ( ) | Ext. | Fax Number ( ) | Email Address |
|---|---|---|---|
| | | | |

**Mailing Address**

*Complete this section if you* ***do not want*** *your correspondence sent to the Primary Practice Address.*

| Information Line *(e.g. c/o name, department of, to the attention of, floor)* | |
|---|---|
| Address *(apt. / suite, street no. & name)* | |

| City | Province | Country | Postal Code |
|---|---|---|---|
| | | | |

| Telephone Number ( ) | Ext. | Fax Number ( ) | Email Address |
|---|---|---|---|
| | | | |



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## Section 5 – Medical Claims Electronic Data Transfer (MC EDT) and Health Card Validation (HCV) Service Information

Your claims must be submitted through the ministry's electronic data transfer service as per the *Health Insurance Act* Ontario Regulation 552, Section 38.3. The ministry will send you a letter confirming your registration and your OHIP billing number. This letter will also contain information on Medical Claims Electronic Data Transfer (MC EDT) and Health Card Validation methods.

## Section 6 – Payment Information

I hereby authorize the ministry to make direct bank payment to my account. I have attached a scanned or original blank cheque with "VOID" written on it from the financial institution where I bank with the fully micro-encoded branch, institution and account numbers.

## Section 7 – Declaration

I declare the information provided to be true and I consent to allow the Ministry of Health to verify, with other sources, all information I have given in this application. These sources may include but are not limited to the Governing Body of my related Health Profession *(e.g. College of Physicians and Surgeons of Ontario, College of Midwives of Ontario)* and the medical school(s) and hospitals indicated in my application.

I understand that in applying for and subsequently receiving my OHIP billing number(s) that I am subject to the provisions of the *Health Insurance Act* and Regulations under the Act. I am responsible to read and understand the information, including but not limited to:

- INFOBulletins related to payment policy — http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html
- Schedule of Benefits — http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html
- Regulation 57/97 under the *Health Insurance Act* — http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_970057_e.htm
- Regulation 552 under the *Health Insurance Act* — http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_ev002.htm

I understand that it is my responsibility to comply with the *Health Insurance Act* and Regulations under that Act, including, in the case of physicians, the Schedule of Benefits and that all claims must be submitted in accordance with that Act and Regulations thereunder. I acknowledge that only claims for services provided by me may be submitted under the OHIP billing number(s) assigned to me and that I am solely responsible for the veracity of those claims, regardless of who may prepare and/or submit claims for those services on my behalf and regardless of to whom payment is made.

It is a provincial offence to contravene the *Health Insurance Act* or any Regulations under that Act.

I understand that as a health information custodian I am required under the *Personal Health Information Protection Act*, 2004 to take steps that are reasonable in the circumstances to ensure that personal health information in my custody and control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing that information are protected against unauthorized copying, modification or disposal.

I further understand that this obligation applies in connection with personal health information that I receive from or submit to the ministry in connection with OHIP billings.

_____ _____

Signature Date *(yyyy/mm/dd)*

**For more information on completing this application and / or applying for an OHIP billing number, contact the ministry's Service Support Contact Centre by email: SSContactCentre.MOH@ontario.ca or by calling 1-800-262-6524.**



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