Ontario Ministry of Health

# Change of Address for Health Care Professionals

**Instructions:**

Health Care Professionals will complete this form to update their address information with the Ministry of Health (the ministry). You must give the ministry ***at least 30 days*** advance notice of any changes to your address information referred to below.

- Primary Practice Address - the site at which the majority of insured services is expected to be rendered.
- Additional Site Address - use additional sheet if necessary.
- Mailing Address - for ministry correspondence to be sent if different than the primary practice address (must be a Canadian address).

For more information on completing this form, please contact the ministry's Service Support Contact Centre by email: SSContactCentre.MOH@ontario.ca or by calling 1-800-262-6524.

## Section 1 - Personal Information

| Last Name | First Name | OHIP Billing Number *(if applicable)* |
|---|---|---|
| | | |

## Section 2 - Primary Practice Address

*(PO Box and RR Number are not acceptable)*

Effective Date of Change *(yyyy/mm/dd)*

| Unit Number | Street Number | Street Name |
|---|---|---|
| | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | ON | |

| Telephone Number ext. | Fax Number | Email Address |
|---|---|---|
| | | |

## Section 3 - Additional Site Address

◯Add ◯Change ◯Cancel

☐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)*

Effective Date of Change *(yyyy/mm/dd)*

| Unit Number | Street Number | Street Name |
|---|---|---|
| | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | ON | |

| Telephone Number ext. | Fax Number | Email Address |
|---|---|---|
| | | |

## Section 4 - Mailing Address

◯Add ◯Change ◯Cancel

Information line *(e.g. c/o name, department of, to the attention of, floor)*

Effective Date of Change *(yyyy/mm/dd)*

| Unit Number | Street Number | Street Name |
|---|---|---|
| | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | ON | |

| Telephone Number ext. | Fax Number | Email Address |
|---|---|---|
| | | |

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Submit this form 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

## Section 5 - Signature

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 update your address information 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.

| Name | Signature | Date (yyyy/mm/dd) |
|---|---|---|
| | | |