Ontario Ministry of Health

# Drug Benefit Claim Reversal Form

Ticket Number

## Instructions

Fields marked with an asterisk (*) are mandatory.

## 1. Reversal Information

| Provider I.D. (Must be on all submitted pages) * | Number of Pages Submitted (including this form) * |
|---|---|
| | |

Please complete the table (maximum of 10 records).

| Transaction Date | Client I.D./ Code (ODB Eligibility/ Health No.) * | Rx Number * | DIN/PIN | Amount Billed to ODB * |
|---|---|---|---|---|
| | | | | |
| | | | **Total $** | |

If submitting a high volume of reversals please submit additional pages or a report containing the identical columns of information and the Provider I.D. as per this form for processing.

☐ Additional pages attached listing records for reversal.

## 2. Comments

## 3. Signature

The information contained in this form, including those on paper and electronic media, is being collected under the *Personal Health Information Protection Act*, *2004* and the *Ontario Drug Benefit Act* for the purpose of administering Ontario public drug programs. For information contact: Director, Drug Programs Policy and Strategy Branch, 3rd Floor, 5700 Yonge Street, Toronto ON M2M 4K5 or call 416-327-8109.

I authorize the ministry to adjust my account by the amount described above.

Submit this Claim to: **Ministry of Health**
**Claims Services Branch**
Fax: **1-613-237-3246**
Telephone inquiry number: **1-800-668-6641**

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

**Note:** Pharmacists are required to retain a copy of the Drug Benefit Claim Reversal Form on file for a period of two years from the day of claim reversal submission.

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