Ontario Ministry of Health

Drug Benefit Claim Submission Form

Ticket Number	Resubmission Number

Instructions

Fields marked with an asterisk (*) are mandatory.

1. Reason For Submission

- ☐ ODB Eligibility for Claim Could Not Be Verified Electronically (>7 days)
- ☐ > 2 Intervention/Exception Codes
- ☐ > 99 Minutes Compounding Time
- ☐ Valid Claim Value is > $9,999.99
- ☐ Ministry Authorized Submission

2. General Information

Provider Transaction Date (yyyy/mm/dd) *	Provider I.D. *	Client I.D./Code (**ODB Eligibility/Health No.**) *	Version

3. Client Information

Patient Last Name *	Patient First Name *	Middle Initial

Patient Date of Birth (yyyy/mm/dd) *	Sex *	Carrier I.D. (Plan Code) *	Group Number/Code (Long Term Care Agency I.D.)

4. Prescription Service Information

DIN/PIN *	Current Prescription Number *	Quantity *	Day(s) Supply *	Prescriber I.D. *	Prescriber I.D. Ref. *

Drug Cost/Product Value *	Cost Upcharge *	Professional Fee *	Special Service Code/SSC	Product Selection Code

Unlisted Compound Type	Compounding Time	Compounding Charge	Medical Reason Ref.	Medical Condition – Reason for Use	Special Authorization Number/Code

Please insert the Pharmacist I.D. and select the applicable code(s) (maximum of 5 Intervention/Exception Codes).

Pharmacist I.D. *

- ☐ LU: start new LU authorization.
- ☐ MH: override prescriber I.D.
- ☐ MI: no interchangeable available at less than or equal to DBP plus 10 percent.
- ☐ MJ: government pharmacy authorized claim.
- ☐ ML: eligibility established - standard coverage
- ☐ MM: replacement claim, drug cost only.
- ☐ MN: replacement claim due to dose change.
- ☐ MO: valid claim value of $500.00 to $999.99.
- ☐ MP: valid claim value of $1,000.00 to $9,999.99.
- ☐ MQ: valid claim – quantity over limit.
- ☐ MR: replacement, item lost or broken.
- ☐ MV: vacation supply.
- ☐ MW: valid reason to exceed eligibility established limit.
- ☐ MZ: required prior therapy documented.
- ☐ NF: override – quantity appropriate.
- ☐ NH: initial Rx program declined.
- ☐ PB: name entered is consistent with card.
- ☐ PS: professional service (only for use in submissions with >2 intervention codes)
- ☐ UA: consulted prescriber and filled Rx as written.
- ☐ UB: consulted prescriber and changed dose.
- ☐ UC: consulted prescriber and changed instructions for use.
- ☐ UE: consulted prescriber and changed quantity.
- ☐ UF: patient gave adequate explanation. Rx filled as written.
- ☐ UG: cautioned patient, Rx filled as written.
- ☐ UN: assessed patient. Therapy is appropriate.

5. Comments

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6. 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 certify that the information provided in this claim is true, accurate and complete.

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 Submission Form on file for a period of two years from the day of claim submission.