Ministry of Health
Primary Health Care Branch
Northern Health Programs
Fax: 705-564-7493
Email: NHP@ontario.ca

Outreach Program Monthly Billing

Instructions for completion of the Outreach Program Monthly Billing form

Program #140501

Refer to program guidelines or visit our website at https://www.ontario.ca/document/northern-health-programs/physician-outreach-program-generalfamily-practitioners-guidelines for more information.

Physician Remuneration

Enter Date, Clinic Hours, Travel Hours and Total Outreach Hours as indicated.

a) $244.71 honorarium plus fee-for-service for each day of outreach service or

b) $244.71 honorarium plus $611.76 stipend for each day of outreach service. Physicians are encouraged to bill fee-for-service rather than stipend on days that at least $611.76 can be billed to the Ontario Health Insurance Plan.

A day of “outreach service” consists of a maximum of six hours (this includes clinic time and travel to and from the physician’s normal place of practice). The minimum length of a clinic is two hours. Neither the stipend nor the honorarium may be claimed for clinics of less than two hours. For less than six hours of outreach service (i.e., the minimum two-hour clinic plus travel time) the $611.76 stipend will be pro-rated accordingly while the honorarium remains at $244.71.

Physician Telephone Back-up: $367.05 per month per UAP nursing station. This amount may be shared between two or more physicians.

Submitting Outreach Program Monthly Billing Form

Please ensure that you print your name, your mailing address, sign the form and if applicable ensure that the authorized Nursing Station Official signs in the appropriate section of the form prior to sending it via:

Northern Health Programs
Email: NHP@ontario.ca or Fax: 705-564-7493

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Section 1. Outreach Program Monthly Billing

Nursing Station Name

For physicians only Are you on an Alternate Payment Plan? ☐ Yes ☐ No

Stipend calculation (only if physician did not bill Fee for Service)

Date	Clinic (Hours)	Travel (Hours)	Total (Hours)	Honorarium (Dollars)	Stipend (Dollars)	Total Amount
					Monthly Telephone Back-Up	
					Total Monthly Claim	

Section 2. Certificate

I certify that the above information is correct

Nursing Station's Authorized Name	Nursing Station's Authorized Signature	Date (yyyy/mm/dd)
Claimant's Name	Claimant's Signature	

Claimant's Mailing Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province		Postal Code

Telephone Number ext.

I authorize this claim, being satisfied as to necessity, reasonableness and accuracy

Name of Analyst	Signature	Date (yyyy/mm/dd)

TPBE	Business Unit	Cost Centre	Account	Total Claim	Recipient Number

The Ministry of Health is authorized to collect the personal information requested in this form for the purpose of properly administering the Ministry's Outreach Program under subsection 6(1) paragraph 4 or clause 6(2)(b) of the *Ministry of Health and Long-Term Care Act,* R.S.O. 1990, c. M. 26. The personal information will be used to assess, verify and monitor eligibility for payment. For information about this collection, please contact Northern Health Programs, at Telephone Number: 705-564-7280 or toll-free at 1-866-727-9959, or via email at NHP@ontario.ca.