Ontario Ministry of Health

Remittance Advice Inquiry

Purpose

Use this form to itemize under or over payments appearing on your Remittance Advice (RA). The ministry will review your inquiry and action with appropriate determinations. Please verify future remittance advices to reconcile the adjustments made. A response will be sent electronically through EDT to advise if the requested adjustment is not made. This form can also be used to request a correction. If a correction for more than 25 claims is required and refers to the same error and same provider, please call 1-800-262-6524.

Do **not** use this form to inquire about claims appearing on an Error Report.

Claims on your Error Report should be corrected and resubmitted.

Important

Submit all inquiries from each RA at the same time. If a claim does not appear on an Error Report or RA after two payment cycles, please resubmit. Inquiries on claims payments must be made **within seven calendar months** from the date of the Remittance Advice OR the ministry's payment decision letter, (whichever is later). However, inquiries on **Final Decisions** (FD) will not be considered.

A code of FD indicates it is the ministry's final decision with respect to the payment of the claim. If the physician wishes to dispute the final decision, a request for a hearing by the Health Services Review and Appeal Board (HSARB) must be made within 30 calendar days from the receipt of the FD.

All sections must be completed.

Provider Contact Information

Date of Inquiry (yyyy/mm/dd)	Date of Remittance Advice (yyyy/mm/dd)	Provider/Group Number

Provider/Group Name

Contact Name	Telephone Number (for billing inquiries)

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Fax Number	Email Address

Check if: UP (Underpayment), OP (Overpayment) or CR (Correction) ☐UP ☐OP ☐CR

Patient Claim Information

Health Number	Claim Number	Accounting Number	Date of Birth (yyyy/mm/dd)

Fee Schedule Code	Date of Service (yyyy/mm/dd)	Fee Submitted

Last Name	First Name

Provider/Group Remarks (provide rationale to assist with the review – attach a separate document if necessary).

Date returned to provider/group (yyyy/mm/dd)

☐Late Inquiry Not Accepted (over 7 months)

☐**F.D.** (**Final Decision** respecting this claim)

☐P.C. (Paid Correctly according to our records)

☐A.R. (Adjustment Required – being processed)

Explanation

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Explanation

Please Direct Any Inquiries To

Name of Ministry Representative	Telephone Number

The ministry's collection of the personal information and personal health information on this form is authorized under the *Health Insurance Act*, RSO 1990, c H6, section 4.1. For information about this collection, contact the Claims Services Branch by calling 1-800-262-6524 or emailing SSContactCentre.MOH@ontario.ca.