Your request has been submitted. Thank you for your submission. Please print/save your application for your personal records. For any further inquiries, please contact OOCPAApplicationRequests.MOH@ontario.ca

Ontario

Ministry of Health

Request for Prior Approval for Full Payment of Insured Out-of-Country (OOC) Health Services

Instructions

The Out-of-Country Prior Approval Program acts as a safety valve to ensure funding is available for medically necessary services that are either not available in Ontario or not available without medically significant delay. There is no discretion under the Health Insurance Act (HIA) or its regulations to make payments under the Ontario Health Insurance Plan (OHIP) for services that do not meet the regulatory requirements (outlined in Part 5 of this application). For more information on this program please visit:
OHIP coverage while outside Canada | ontario.ca.

A practicing Ontario physician must complete the sections of the form that pertain to their request.

This form is designed to be completed and submitted electronically. Mandatory fields must be completed or the form cannot be submitted to the ministry for review.

For assistance in completing an application, please contact the ministry at **1–888–359–8807 or OOCPAApplicationRequests.MOH@ontario.ca.**

Fields marked with an asterisk (*) are mandatory.

Are you providing additional information for a previously submitted application? *

☐Yes ☐No

Previous Prior Approval Number * Ontario Health Card Number * Referring Ontario Physician Email Address *

Is the OOC treatment required as a result of a work-related accident? *

☐Yes ☐No

If yes, **do not** complete this form. Please contact the Workplace Safety and Insurance Board (WSIB) at 1-800-387-0750 or by mail at 200 Front Street West, Toronto, Ontario M5V 3J1.

Please select one *

☐This treatment is medically urgent ☐This treatment is not medically urgent

Explain medical urgency *

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Part 1 – Patient Information

- Before submitting, please verify that your patient's health card is valid. Any funding applications submitted with an expired health card will not be processed by the ministry: https://www.ontario.ca/page/health-card-renewal.
- If the patient is under the age of 16, a parent or legal guardian must be noted as the Substitute Decision Maker.
- If a Substitute Decision Maker is identified on an application where the patient is over the age of 16, documentation must be provided which establishes that the Substitute Decision Maker is legally authorized to make decisions on the patient's behalf.

Last Name * Single Name *

or

First Name (not applicable if Single Name entered) * Middle Initials

Date of Birth (yyyy/mm/dd) *

Is this patient a newborn or a child currently without a health card? *

☐Yes ☐No

Ontario Health Card Number * Version Code

Current Mailing Address

Postal Code * (if necessary, continue to select the Postal Code Lookup button until your correct address is shown)

Unit Number Street Number * Street Name *

PO Box/Rural Route/General Delivery City/Town * Province/Territory *

ON

Telephone Number (Preferred) * Telephone Number (Alternate)

ext.

Email Address (if available)

☐ By checking this box, I confirm that the patient named above, or relevant Substitute Decision Maker where applicable, has been informed by the Applicant that the patient's personal health information (PHI), as such term is defined in the *Personal Health Information Protection Act, 2004* (PHIPA), as amended, will be collected and used by the Ministry of Health in order to assess the patient's eligibility to receive funding for the requested service pursuant to the criteria as set out by the Out-of-Country Prior Approval Program and that this information will be securely stored and only used and disclosed as may be permitted or required under PHIPA or applicable law including for the purposes of administering the Out-of-Country Prior Approval Program in accordance with the HIA. This may involve the disclosure of PHI to health care providers, institutions and agencies that require it for that purpose. *

Name of Substitute Decision Maker (if applicable)

Last Name Single Name

or

First Name (not applicable if Single Name entered) Middle Initials

Part 2 – Referring Ontario Physician

This funding request must be submitted by a physician who practices medicine in Ontario, or, in cases requesting emergency services, by an emergency patient referral service.

"Emergency circumstances" means medical circumstances in which an insured person faces **immediate** risk of,

(a) death, or

(b) medically significant irreversible tissue damage;

"Emergency patient referral service" means a person, agency or organization operating in Ontario that,

(a) is approved by the General Manager of OHIP, and

(b) provides information to physicians, hospitals or health facilities about health services available in emergency circumstances;

Physician Last Name *

Physician First Name *

Practice/Office Address

Postal Code * (if necessary, continue to select the Postal Code Lookup button until your correct address is shown)

Unit Number

Street Number *

Street Name *

PO Box/Rural Route/General Delivery

City/Town *

Province/Territory *

ON

Telephone Number where we can reach you *

ext.

Fax Number

Physician Specialty

Physician Email Address *

OHIP Billing Number *

FIPPA Notice: Collection of physician information contained in this form is for the purposes of the administration of the HIA, including determining eligibility of the insured Ontario resident for OHIP funding of OOC health services. Collection of this information is authorized under section 4.1 of the HIA. If you have any questions about this collection, please contact the program area at 1-888-359-8807.

Part 3 – Diagnosis and Requested Service

Clinical Diagnosis of Patient *

Please check the box for the required treatment/service(s) *

☐ OOC consultation with a view to treatment within the province

Please outline the specialty/specialties from whom you are seeking an opinion *

Is there any diagnostic testing required OOC in addition to the OOC consultation? *

☐ Yes ☐ No

If yes, please outline what diagnostic testing is required OOC and provide an explanation as to why testing cannot be performed in Ontario *

Supporting documentation is mandatory for an application to be considered complete. Please confirm:

☐ All relevant medical records including but not limited to hospital discharge summaries, consult notes, relevant diagnostic imaging reports will be attached where indicated in Part 6 of the form *

☐ OOC consultation with a view to treatment outside of the country

Please outline the specialty/specialties from whom you are seeking an opinion and what treatment the consultation is being considered for *

Is there any diagnostic testing required OOC in addition to the OOC consultation? *

☐ Yes ☐ No

If yes, please outline what diagnostic testing is required OOC and provide an explanation as to why testing cannot be performed in Ontario *

Supporting documentation is mandatory for an application to be considered complete. Please confirm:

☐ All relevant medical records including but not limited to hospital discharge summaries, consult notes, relevant diagnostic imaging reports will be attached where indicated in Part 6 of the form *

☐ Surgery (non-cancer related)

Proposed surgical procedure *

Please outline if this surgery includes any pre-operative and post-operative requirements and inpatient physical and occupational therapy for the patient to be rendered OOC in support of the requested surgery *

Supporting documentation is mandatory for an application to be considered complete. Please confirm:

☐ All relevant medical records including but not limited to hospital discharge summaries, consult notes, relevant diagnostic imaging reports will be attached where indicated in Part 6 of the form *

☐ Cancer Treatment

All funding requests for OOC cancer services are reviewed by Ontario Health (Cancer Care Ontario) who require additional clinical information pertaining to the patient's circumstance. Please download, fill out and save the Out of Country Prior Approval Program CCO Questionnaire. Once completed, please upload and submit with other supporting documentation in Part 6 of this form.

For services that have already been performed OOC please download, fill out and save the Out of Country Prior Approval Program CCO Questionnaire (Performed Services). Once completed, please upload and submit with other supporting documentation in Part 6 of this form.

Please note that supporting documentation is mandatory for an application to be considered complete.

Choose Treatment/Service Provider - U.S. Preferred Providers (check one) *

☐ Proton Beam Therapy (proton beam therapy, with or without chemotherapy and anesthesia)

☐ Paediatric Patients (under 18 years)

Preferred Provider Facilities (check one) *

☐ Cincinnati Children's Hospital
Cincinnati Children's Proton Therapy Center
7777 Yankee Road Ste 1000
Liberty Township, Ohio 45044

☐ Massachusetts General Hospital
55 Fruit Street, Cox 3-3-4
Boston, Massachusetts 02114

☐ Northwestern Medicine Chicago Proton Center
4455 Weaver Parkway
Warrenville, Illinois 60555

☐ University of Florida Health Proton Therapy Institute
2015 N Jefferson Street
Jacksonville, Florida 32206

☐ MD Anderson Cancer Center
1515 Holcome Boulevard
Houston, Texas 77030

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Adult Patient (18 years of age or older)

Preferred Provider Facilities (check one) *

☐ Northwestern Medicine Chicago Proton Center
4455 Weaver Place
Warrenville, Illinois 60555

☐ University of Florida Health Proton Therapy Institute
2015 N Jefferson Street
Jacksonville, Florida 32206

☐ University of Pennsylvania Health System ("Penn Medicine")
3920 Chestnut Street
Philadelphia, Pennsylvania 19104

☐ MD Anderson Cancer Center
1515 Holcome Boulevard
Houston, Texas 77030

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Chimeric Antigen Receptor (CAR) T-cell Therapy

Preferred Provider Facilities (check one) *

☐ Cleveland Clinic
DLBCL and ALL
9500 Euclid Avenue
Cleveland, Ohio 44195

☐ Roswell Park Comprehensive Cancer Centre
DLBCL and ALL
665 Elm St
Buffalo, New York 14203

☐ Karmanos Cancer Institute
DLBCL
4100 John R Street
Detroit, Michigan 48201

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance.*
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Other Cancer Service or Treatment

(specify) *

Please check all services/treatments as applicable to be rendered OOC that are requested in addition to the cancer treatment selected above:

☐ Surgery ☐ Radiation ☐ Chemotherapy

☐ Rehabilitation ☐ Gene Therapy/Immune Effector Cell Therapy ☐ Anesthesia

(specify)*

☐ Other

(specify) *

Provide additional information as applicable (e.g., chemotherapy drugs requested, name of surgery, type of rehabilitation required, etc.) *

☐ Please confirm that the Out of Country Prior Approval Program CCO Questionnaire has been completed and will be attached in Part 6 of the form or confirm that your patient was referred to the Out-of-Country Prior Approval Program by an in-province cancer treatment program (e.g. In-Province CAR T-cell Therapy Program) *

☐ Drug Therapy (non-cancer related)

According to Regulation 552 under the *Health Insurance Act*, for a service that consists primarily of the administration of a drug, including the provision of the drug that is administered, it is required that the Executive Officer recommends payment for the drug for a person in the same medical circumstances as the insured person.

Given the above requirement, please confirm the following:

Is the service primarily the administration of a drug, including the provision of the drug that is administered? *

☐Yes ☐No

Is the requested drug for cancer treatment? * (If **Yes**, please complete **Cancer Treatment** section instead of this section.)

☐Yes ☐No

Name of requested drug *

Number of administrations requested *

Indicate if there are any other services required in support of the administration of this drug (e.g., hospital services, laboratory testing, diagnostic imaging)

Is this drug therapy offered as part of a clinical trial? *

☐Yes ☐No

Clinical Trial Number *

Supporting documentation is mandatory for an application to be considered complete, please attach where requested in Part 6 of the form.

☐Emergency Transfer

When acute or life-threatening circumstances require immediate services that are **not available** in an Ontario treating hospital, the referring physician should contact **CritiCall** to determine if there is an available treatment bed at another Ontario hospital.

If **CritiCall** is not able to transfer the patient within Ontario, **CritiCall** may arrange a transfer to an OOC facility. In this case, the referring physician may submit an application (within 24 hours of the transfer) to the ministry on behalf of the patient.

Was the OOC emergency transfer facilitated by CritiCall? *

☐Yes ☐No

Provide details outlining why this OOC emergency transfer was not facilitated by CritiCall *

Service required *

Provide details outlining the emergency circumstances that support the patient was at immediate risk of death or medically significant irreversible tissue damage *

Attach supporting documentation if applicable, where requested in Part 6 of the form.

☐MRI (Magnetic Resonance Imaging)

Are you requesting an Open MRI? * ☐Yes ☐No

Diagnostic Imaging (Open MRI only) - U.S. Preferred Providers (check one) *

☐ Basha Diagnostics
Basha OPEN MRI
30701 Woodward Avenue
Royal Oak, Michigan 48073 USA

☐ Great Lakes Medical Imaging LLC
199 Park Lane, Suite 300
Williamsville, New York 14221 USA

☐ St. Luke's Hospital of Duluth
910 E 2nd Street
Duluth, Minnesota 55805 USA

☐ Western New York MRI, LLP
2882 Elmwood Avenue
Kenmore, New York 14217 USA

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

Explain the medical necessity for an OOC MRI *

Area(s) of body to be scanned (please list all) *

Indicate whether the MRI is with or without contrast *

☐ With Contrast ☐ Without Contrast ☐ With and Without Contrast

Provide your patient's weight * Provide your patient's maximal abdominal girth *

Attach supporting documentation if applicable, where requested in Part 6 of the form.

☐ MRI Ferriscan

Facility *

☐ Resonance Health
141 Burswood Road
Burswood, Western Australia 6100 Australia

Ferriscans are permitted once a year except under limited circumstances.

Type of Ferriscan *

☐ Annual scan

☐ New scan

☐ Repeat scan (additional scan within the same year)

Explain why a repeat scan is required *

Check one *

☐ Scan for Liver Iron Concentration

☐ Dual scan for Liver and Cardiac Iron concentration

☐ Cardiac T2 Scan

Attach supporting documentation as applicable, where requested in Part 6 of the form.

Mental Health Services

☐ Eating Disorder (ED)

Residential Treatment

Complete this section if you have requested funding for residential treatment outside Canada for a patient with a diagnosis of an ED. Please visit the Checklist – OOC Treatment for Eating Disorders for ED application requirements and ensure that all medical documentation required in support of your application are uploaded in Part 6 of the form.

Mental Health Services - ED Treatment - U.S. Preferred Providers (check one) *

☐ Paediatric Patients (under 18 years)

Preferred Provider Facility *

☐ Residential Treatment at the Eating Disorder Center
Rogers Memorial Hospital
34700 Valley Road
Oconomowoc, Wisconsin 53066

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 12

☐ Residential Treatment at Denver Pine
Eating Recovery Center
98 Spruce Street
Denver, Colorado 80230

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 12

☐ Inpatient Treatment at Denver Pine
Eating Recovery Center
98 Spruce Street
Denver, Colorado 80230

Diagnoses: Eating Disorders
Level of Care: Inpatient
Minimum Age: 12

☐ Residential Treatment at Denver Jupiter
Eating Recovery Center
1830 Franklin St.
Denver, Colorado 80218

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 12

☐ Inpatient Treatment at Denver Jupiter
Eating Recovery Center
1830 Franklin St.
Denver, Colorado 80218

Diagnoses: Eating Disorders
Level of Care: Inpatient
Minimum Age: 12

Residential Treatment at Plano Baylor
Eating Recovery Center
4708 Alliance Blvd.
Plano, Texas 75093

☐

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 12

Inpatient Treatment at Plano Baylor
Eating Recovery Center
4708 Alliance Blvd.
Plano, Texas 75093

☐

Diagnoses: Eating Disorders
Level of Care: Inpatient
Minimum Age: 12

Residential Treatment at Plano Legacy
Eating Recovery Center
5120 Legacy Dr.
Plano, Texas 75024

☐

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 12

Inpatient Treatment at Plano Legacy
Eating Recovery Center
5120 Legacy Dr.
Plano, Texas 75024

☐

Diagnoses: Eating Disorders
Level of Care: Inpatient
Minimum Age: 12

Residential Treatment at Dedham Facility
Walden Behavioral Care
10 Carematrix Drive
Dedham, Massachusetts 02026

☐

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 11

Inpatient Treatment at Dedham Facility
Walden Behavioral Care
10 Carematrix Drive
Dedham, Massachusetts 02026

☐

Diagnoses: Eating Disorders
Level of Care: Inpatient
Minimum Age: 11

☐ Preferred Provider Facility noted above is not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Adult Patient (18 years of age or older)

Preferred Provider Facilities (check one) *

The Eating Disorders Treatment Center
River Oaks Hospital,
1525 River Oaks Road West
New Orleans Louisiana

☐

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 18

Residential Treatment at the Eating Disorder Center
Rogers Memorial Hospital, Oconomowoc WI
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Eating Disorders
Level of Care: Residential
Minimum Age: 18

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Obsessive Compulsive Disorder (OCD)

Residential Treatment

Complete this section if you have requested funding for residential treatment outside Canada for a patient with a diagnosis of OCD. Please visit the Checklist – OOC Treatment for Obsessive Compulsive Disorders for OCD application requirements and ensure that all medical documentation required in support of your application are uploaded.

Mental Health Services - OCD Treatment - U.S. Preferred Providers (check one) *

☐ Paediatric Patients (under 18 years)

Preferred Provider Facility *

Residential Treatment at the Child and Adolescent Centers
Rogers Memorial Hospital
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Obsessive Compulsive Disorder
Level of Care: Residential
Minimum Age: 8

☐ Preferred Provider Facility noted above is not suitable

Provide a rationale as to why the preferred provider facility listed above is not sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Adult Patient (18 years of age or older)

Preferred Provider Facilities (check one) *

Partial Hospitalization Program for Adults
Rogers Memorial Hospital
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Obsessive Compulsive Disorder
Level of Care: Day Treatment
Minimum Age: 18

Residential Treatment at the OCD Center
Rogers Memorial Hospital
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Obsessive Compulsive Disorder
Level of Care: Residential
Minimum Age: 18

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Trauma-Based Disorders

Residential Treatment

Supporting documentation (relevant medical records/discharge summaries/consult notes) is mandatory for an application to be considered complete, please attach where requested in Part 6 of the form.

Mental Health Services - Trauma-Based Disorders Treatment - U.S. Preferred Providers (check one) *

☐ Paediatric Patients (under 18 years)

Preferred Provider Facility *

Residential Treatment at the Child and Adolescent Centers
Rogers Memorial Hospital
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Spectrum of child and adolescent psychiatric disorders
Level of Care: Residential
Minimum Age: 8

☐ Preferred Provider Facility noted above is not suitable

Provide a rationale as to why the preferred provider facility listed above is not sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Adult Patient (18 years of age or older)

Preferred Provider Facilities (check one) *

Partial Hospitalization Program / Cognitive Behavioural Therapy for Depression and Anxiety Disorders
Rogers Memorial Hospital - Oconomowoc
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Depression and Anxiety Disorders
Level of Care: Day Treatment
Minimum Age: 18

Partial Hospitalization Program / Cognitive Behavioural Therapy for Depression and Anxiety Disorders
Rogers Memorial Hospital – West Allis
11101 West Lincoln Avenue
West Allis, Wisconsin

☐

Diagnoses: Depression and Anxiety Disorders
Level of Care: Day Treatment
Minimum Age: 18

The New Orleans Institute: Trauma-Based Mental Disorders Program
River Oaks Hospital
1525 River Oaks Road West
New Orleans Louisiana

☐

Diagnoses: Post-Traumatic Stress Disorder, Dissociative Identity Disorder, Major Depressive Disorder, etc. with/without Substance Abuse
Level of Care: Residential
Minimum Age: 18

Partial Hospitalization Program for Post-Traumatic Stress Disorder
Rogers Memorial Hospital – Oconomowoc
34700 Valley Road
Oconomowoc, Wisconsin 53066

☐

Diagnoses: Post Traumatic Stress Disorder
Level of Care: Day Treatment
Minimum Age: 18

Partial Hospitalization Program for Post-Traumatic Stress Disorder
Rogers Memorial Hospital – West Allis
11101 West Lincoln Avenue
West Allis, Wisconsin 53227

☐

Diagnoses: Post Traumatic Stress Disorder
Level of Care: Day Treatment
Minimum Age: 18

☐ Preferred Provider Facilities noted above are not suitable

Provide a rationale as to why none of the preferred provider facilities listed above are sufficient given your patient's clinical circumstance. *
(Additional medical documentation outlining this rationale may be submitted in Part 6 of the application.)

☐ Other Disorders

(specify) *

Residential Treatment

Supporting documentation (relevant medical records/discharge summaries/consult notes) is mandatory for an application to be considered complete, please attach where requested in Part 6 of the form.

☐ Other Service(s)

(specify) *

Supporting documentation is mandatory for an application to be considered complete. Please confirm:

☐ All relevant medical records including but not limited to hospital discharge summaries, consult notes, relevant diagnostic imaging reports will be attached where indicated in Part 6 of the form *

If the proposed service(s) was not selected as a checkbox earlier in this section, please identify the Proposed Services(s)

Provide anticipated start date of OOC services if determined (yyyy/mm/dd)

Prior approval from OHIP is required **before** services are rendered unless there were emergency circumstances at the time the service was rendered. If this funding request is for services received without prior approval, the application must include medical documentation that supports that the services were rendered in emergency circumstances. For clarity, "emergency circumstances" means medical circumstances in which an insured person faces immediate risk of,

(a) death, or

(b) medically significant irreversible tissue damage

Have OOC services already been received without ministry approval? *

☐ Yes ☐ No

If yes, Date of Service (yyyy/mm/dd) *

Details of emergency circumstances *

Part 4 – Proposed OOC Hospital/Health Facility

OHIP only funds medical services that are performed at a hospital or health facility as defined in subsection 28.4(1) of Regulation 552 under the *Health Insurance Act*:

Preferred Provider Agreements (PPA) - U.S.A. Providers (chosen in Part 3)

Name of Hospital/Health Facility/Address *

Name of Hospital/Health Facility *

☐ U.S.A. ☐ Other International

Unit Number Street Number * Street Name *

PO Box/Rural Route/General Delivery City/Town *

Province/Territory/State Postal/Zip Code Country *

Name of ☐OOC Physician ☐Contact Person at Hospital

First Name Last Name

Telephone Number Fax Number

ext.

Email Address

Website Address

Part 5 – Regulatory Requirements

Instructions

For this application to be considered for OHIP funding, specific regulatory criteria (Regulation 552 under the *Health Insurance Act*) must be met. As the applying physician, you may complete this section if you are requesting funding for a service that is within your scope of practice. If you are requesting funding for health services that are outside of your scope of practice, you must include written confirmation from a specialist in the type of service for which funding is sought that the OOC funding criteria are met.

Declaration:

I confirm: *

☐ that the requested service is within my scope of practice and all the following regulatory criteria required for the requested OOC health service(s) are met.

or

☐ that the requested service is not within my scope of practice, and I have included written confirmation from the appropriate specialist that all the following regulatory criteria required for the requested OOC health service(s) are met.

Name of specialist consulted:

Last Name * First Name *

The requested OOC medical services are:

Generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person *

☐Yes ☐No

Medically necessary *

☐Yes ☐No

Either, the identical or equivalent service(s) is/are *

☐not performed in Ontario,

or

☐performed in Ontario, but the insured person must travel outside of Canada to avoid a delay that would result in either death or medically significant irreversible tissue damage; and

How soon does the patient require the requested service(s) (estimated number of days, weeks, or months, please specify)? *

If the requested service is performed in Ontario what is the estimated length of waiting period in Ontario (estimate number of weeks or months)*

List the names of physician(s) and/or health facilities contacted to determine wait times for the service(s) within the province*

In addition:

Is/are the requested service(s) an examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program? *

☐Yes ☐No

Is/are the requested service(s)/treatment for a medical condition that is generally accepted within Ontario as experimental? *

☐Yes ☐No

Part 1 – Medical Records and Physician Confirmation of Completion

Part 6 – Medical Records and Physician Confirmation of Completion

Supporting medical records are required for a complete application.

The total size of all attachments must not be more than 15 MB.

1. File Name

Total File Size

Please confirm below:

☐ **I have attached all relevant medical records including but not limited to hospital discharge summaries, consult notes, relevant diagnostic imaging, reports and any other mandatory documentation as outlined in this form.** *

☐ **I confirm that the information provided in this application is accurate and complete.** *

Date of Submission

Confirmation Number

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