Ontario Ministry of Health

Request for Prior Approval for Funding of Sex-Reassignment Surgery

Sex-reassignment surgery (SRS) is insured under the Ontario Health Insurance Plan (OHIP) when prior authorization has been obtained from the Ministry of Health (ministry).

Instructions

1. This SRS application must be completed to request prior approval for full payment by the ministry for insured SRS.
2. For patients requesting in-province or out-of-province within Canada services, this form must be completed by an attending physician or nurse practitioner.
3. In accordance with subsection 28.4(7) of Regulation 552 under the *Health Insurance Act*, patients seeking insured SRS out-of-country (OOC) must have section 6 of this form completed by a practicing Ontario physician.
4. Regardless of the proposed service location, referring providers will be notified by letter regarding the outcome of this funding application. A copy of the notification will also be provided to the patient.
5. Please ensure the patient's health number and address is correct and current (i.e., they must match the information on the ministry's database) or the application will be returned.
6. If completed manually, print clearly and ensure that all sections of this form are submitted. Incomplete or illegible forms will be returned.
7. When complete, fax form to: Health Services Branch, Program Manager, SRS Program at 1-613-536-3188. For information or clarification regarding this form, please call 1-866-684-8620.

Supporting Assessments

This prior authorization request must include supporting assessment(s) that recommend surgery and confirm that the criteria listed in the Schedule of Benefits for Physician Services are met.

The supporting assessment(s) must be completed by a provider trained in the assessment, diagnosis, and treatment of gender dysphoria in accordance with the World Professional Association for Transgender Health (WPATH) Standards of Care that are in place at the time of the recommendation.

A provider must be able to provide documentation of their training in the assessment, diagnosis and treatment of gender dysphoria on request by the ministry.

The physician or nurse practitioner submitting a request for prior authorization may also be one of the providers completing a supporting assessment.

Supporting assessments recommending surgery may be provided by an appropriately trained:

1. Physician;
2. Nurse Practitioner;
3. Registered Nurse;
4. Registered Psychologist; or
5. Registered social worker.

Note: "Registered social worker" refers to a social worker who has a master's degree in social work and who holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

Checklist

Prior to submitting this application, please ensure that you have completed and/or included:

☐ Section 1 - Location of Services

☐ Section 2 - Patient Information

☐ Section 3 - Referring Physician or Nurse Practitioner

☐ Section 4 - Proposed Health Facility/Hospital

☐ Section 5 - Treatment- General Information

☐ Section 6 - Treatment Availability (This section should be completed only for patients seeking OOC services and must be completed by an Ontario physician)

☐ Section 7 - Signatures

☐ Section 8 - Supporting Assessments

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Ontario Ministry of Health

Request for Prior Approval for Funding of Sex-Reassignment Surgery

Ministry Use Only	
Date Recorded (yyyy/mm/dd)	Reference Number

Section 1 - Location of Services

☐ In-Province (Complete all sections except Section 6)

☐ Out-of-Province/Within Canada (Complete all sections except Section 6)

☐ Out-of-Country (Complete all sections)

Section 2 - Patient Information

Last Name	First Name	
Preferred Name	Date of Birth (yyyy/mm/dd)	Health Number and Version Code

Current Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number (Home)	Telephone Number (Daytime)	Email Address (if available)

Section 3 - Referring Physician or Nurse Practitioner

Last Name	First Name

OHIP Provider Number (if applicable)

Office Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Fax Number	Email Address (if available)

Section 4 - Proposed Health Facility/Hospital

Facility Name

Name of Physician or Contact Person at Health Facility or Hospital

Last Name	First Name

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Fax Number	Email Address (if available)

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Section 5 - Treatment - General Information

Clinical Diagnosis (condition for which treatment is sought) : Gender Dysphoria

Proposed procedure(s) for which prior approval is requested – check all that apply:

- ☐ Vaginoplasty
- ☐ Phalloplasty
- ☐ Metoidioplasty
- ☐ Glansplasty
- ☐ Scrotoplasty
- ☐ Urethroplasty
- ☐ Vaginectomy
- ☐ Penectomy
- ☐ Clitoral Release
- ☐ Testicular Implants
- ☐ Penile Implant
- ☐ Hysterectomy
- ☐ Salpingo-oophorectomy
- ☐ Orchidectomy
- ☐ Mastectomy
- ☐ Augmentation Mammoplasty

☐ Post-Surgical Complication

Additional surgery that is required because of complications causing significant physical symptoms or functional impairment is insured when prior authorization has been obtained from the ministry. Please use the space below to explain the proposed procedure and the nature of the post-surgical complication, including significant physical symptoms or functional impairment.

Section 6 - Treatment Availability (For patients seeking OOC services only. This section must be completed by a practicing Ontario physician.)

Is this treatment generally accepted in Ontario as appropriate for a person in these medical circumstances? ☐ Yes ☐ No

Is this treatment performed in Ontario by an identical or equivalent procedure? ☐ Yes ☐ No

If “yes”, where is this service performed in Ontario?

Is this treatment required out of Canada to avoid a delay in obtaining the treatment in Ontario that would

A) Result in death or ☐ Yes ☐ No B) Result in medically significant irreversible tissue damage ☐ Yes ☐ No

If “yes” to either of the above, how soon is the treatment required?

If tissue damage is reasonably expected to result from delay, describe the type of damage:

Name of Physician(s) Contacted to Determine Availability of Treatment

Last Name	First Name

Estimated length of waiting period in Ontario (weeks/months)

To be completed by the physician confirming that the OOC funding requirements are met:

Last Name	First Name

OHIP Provider Number (if applicable)	Telephone Number

Signature	Date (yyyy/mm/dd)

Section 7 - Signatures

All accompanying documents will be considered as part of this application.

It is an offence to knowingly give false information to the Ontario Health Insurance Plan in any application or statement made to the plan.

I hereby declare the information provided by me regarding the proposed treatment to be true.

Signature from Physician/Nurse Practitioner	Date (yyyy/mm/dd)

This assessment form must be completed by a qualified provider as described on page 1 of the "Request for Prior Approval for Funding of Sex-Reassignment Surgery" form.

Section 8 - Supporting Assessments

Assessment 1: External Genital Surgery and/or Hysterectomy, Salpingo-Oophorectomy, Orchidectomy

Check relevant procedures:

☐ **External Genital Surgery (clitoral release, glansplasty, metoidioplasty, penectomy, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, vaginoplasty)**

☐ **Hysterectomy, Salpingo-oophorectomy, Orchidectomy**

Instructions: Please attach two supporting assessments from appropriately trained providers confirming the patient is an appropriate candidate for surgery, including:

i. One assessment from a physician or nurse practitioner; and

ii. One assessment from a different physician, a different nurse practitioner, registered nurse, registered psychologist or registered social worker.

Patient Information

Last Name	First Name	
Preferred Name	Date of Birth (yyyy/mm/dd)	Health Number and Version Code

Current Mailing Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province		Postal Code
Telephone Number (Home)	Telephone Number (Daytime)	Email Address (if available)	

Provider Information

Last Name	First Name
OHIP Provider Number (if applicable)	

Office Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province		Postal Code
Telephone Number	Fax Number	Email Address (if available)	

Declaration:

I recommend _____ as an appropriate
(name of insured person)

candidate for the requested surgery and confirm that I have assessed this patient and confirm they meet all of the following criteria:

☐ I have diagnosed the patient with persistent gender dysphoria.

☐ Patient has completed twelve (12) continuous months of hormone therapy (unless hormones are contraindicated); and

☐ Patient has completed twelve (12) continuous months of living in a gender role that is congruent with their gender identity (External Genital Surgery only)

Signature	Date (yyyy/mm/dd)

This assessment form must be completed by a qualified provider as described on page 1 of the "Request for Prior Approval for Funding of Sex-Reassignment Surgery" form.

Assessment 2: External Genital Surgery and/or Hysterectomy, Salpingo-Oophorectomy, Orchidectomy

Check relevant procedures:

☐ **External Genital Surgery (clitoral release, glansplasty, metoidioplasty, penectomy, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, vaginoplasty)**

☐ **Hysterectomy, Salpingo-oophorectomy, Orchidectomy**

Patient Information

Last Name	First Name	
Preferred Name	Date of Birth (yyyy/mm/dd)	Health Number and Version Code

Current Mailing Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province	Postal Code	
Telephone Number (Home)	Telephone Number (Daytime)	Email Address (if available)	

Provider Information

Last Name	First Name
OHIP Provider Number or Professional Designation	

Office Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province	Postal Code	
Telephone Number	Fax Number	Email Address (if available)	

Declaration:

I recommend _____ as an appropriate
(name of insured person)

candidate for the requested surgery and confirm that I have assessed this patient and confirm they meet all of the following criteria:

- ☐ I have diagnosed the patient with persistent gender dysphoria.
- ☐ Patient has completed twelve (12) continuous months of hormone therapy (unless hormones are contraindicated); and
- ☐ Patient has completed twelve (12) continuous months of living in a gender role that is congruent with their gender identity (External Genital Surgery only)

Signature	Date (yyyy/mm/dd)

This assessment form must be completed by a qualified provider as described on page 1 of the "Request for Prior Approval for Funding of Sex-Reassignment Surgery" form.

Supporting Assessment: Chest Surgery

Check relevant procedures:

☐ **Mastectomy**

☐ **Augmentation Mammoplasty**

Instructions: Please attach one assessment from an appropriately trained Ontario physician or nurse practitioner confirming the patient is an appropriate candidate for surgery.

Patient Information

Last Name	First Name	
Preferred Name	Date of Birth (yyyy/mm/dd)	Health Number and Version Code

Current Mailing Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province	Postal Code	
Telephone Number (Home)	Telephone Number (Daytime)	Email Address (if available)	

Provider Information

Last Name	First Name
OHIP Provider Number (if applicable)	

Office Address

Street Number	Unit Number	Street Name	PO Box
City/Town	Province	Postal Code	
Telephone Number	Fax Number	Email Address (if available)	

Declaration:

I recommend _____ as an appropriate
(name of insured person)

candidate for the requested surgery and confirm that I have assessed this patient and confirm they meet all of the following criteria:

☐ Has a diagnosis of persistent gender dysphoria; and

For augmentation mammoplasty surgery only:

☐ Has completed twelve (12) continuous months of hormone therapy with no breast enlargement (unless hormones are contraindicated)

Signature	Date (yyyy/mm/dd)