Ontario

Ministry of Health

Specialty-Service Provider Form for Northern Health Travel Grant

Instructions

This form is to be completed by a Specialty-Service Provider who provides an OHIP-insured service to a patient who is eligible for a Northern Health Travel Grant (NHTG).

Important: This form is to be used only for the purpose of patients looking to submit NHTG applications via the NHTG Online Form. **This form must be included as an attachment and submitted via the NHTG Online Form**, which you can access at the following location: **https://forms.mgcs.gov.on.ca/dataset/on00817**
If you wish to submit by mail, please complete the NHTG Application available on the ministry website: https://forms.mgcs.gov.on.ca/dataset/0327-88

Print clearly in **block letters**.

Fields marked with an asterisk (*) are mandatory.

Section 1: Patient Information

10-Digit Ontario Health Card Number *	Note: If Last Name entered here, First Name is mandatory. * Last Name * **or** Single Name *	
Middle Name	First Name * (not applicable if Single Name entered)	Date of Birth (yyyy/mm/dd) *

Section 2: Specialty-Service Provider Information

The Specialist-Service Provider must complete this section in full.

Date of Service (yyyy/mm/dd) *	Last Name of Specialty-Service Provider *	Initials *
Professional Designation	OHIP Billing Number	Specialty *
Name of Facility where Service Provided *	City/Town Service Provided In *	Telephone Number *

Is this service for a *	☐Consultation	☐Procedure	☐Surgery	☐Follow Up Visit	☐Other			
Is this medical service for an OHIP insured Service? *	☐Yes	☐No						
Is this service WSIB Related? *	☐Yes	☐No						
Was the patient hospitalized during this treatment trip? *	☐Yes	☐No						
Is this medical service for an ADP approved device? *	☐Yes	☐No	If yes, provide ADP vendor number:					
Is this medical service part of the Cleft Lip and Palate Program? *	☐Yes	☐No	If yes, provide Program number:					
Is this medical service part of Ontario Seniors Dental Care Program? *	☐Yes	☐No						
Is this medical service part of Ontario Fertility Program (OFP)? *	☐Yes	☐No						
Number of lodging nights necessary for the patient to access medical care: *	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8+

Physician Fee Code: **K036**	I certify that the information provided is correct. Specialist Provider's Signature *	Date (yyyy/mm/dd) *

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