Clinical Immunology OHIP Billing Cheat Sheet 2026

OHIP specialty 62 · Allergy shot visit · Testing-only visit · Food or drug challenge · Updated November 2026
Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/clinical-immunology

Pick the visit, tick what you did, bill the codes at the bottom. Ontario fees effective July 1, 2026.

Office consultation

A625A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same problem: 1 per 2 years.	$160.30
A525A	Limited consultation A real referral, but a narrow question that needed substantially less time than a full consult (GP19).	$105.25
A626A	Repeat consultation Same problem you consulted on before, another doctor cared for the patient in between, and a new written referral came in (GP19).	$105.25

- Skin prick, patch, drug or venom tests at the consult are paid on top: open the procedure panel (J3).
- New written referral on a problem you've seen before? A626A or A525A pays $105.25, more than a re-assessment A624A ($72.00) or an assessment A623A ($95.95) (GP19).
- Same patient, same diagnosis: 1 consultation per 2 consecutive 12-month periods. Extra ones are paid as an assessment, unless it's an in-patient or ED consult 12–24 months later (GP17).
- No written, signed referral with the referrer's billing number on file: paid as an assessment (GP16). E078A never goes on a consultation (GP25).
- Clinical immunology has no 75-minute comprehensive consult: A130A is only for internal medicine specialists (A129).

Office follow-up

A624A	Medical specific re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee (GP23).	$72.00
A621A	Complex re-assessment, letter to the family doctor Complex, obscure or serious condition. Send your findings in writing to the primary care physician or it is paid as a lesser fee (GP24). Limit: 4 per 12 months (shared with A623A).	$83.40
A623A	Full assessment of a new problem, no referral Full history of the presenting complaint and a detailed exam of the affected systems (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	$95.95
A628A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit (GP25).	$44.75

- Asthma (493), HIV (042–044), lupus, scleroderma or dermatomyositis (710): tick E078A for +50%. A624A becomes $108.00, A621A $125.10, A623A $143.93, A628A $67.13 (GP25–26).
- No E078A for allergic rhinitis (477), urticaria (708), anaphylaxis (995) or hypogammaglobulinaemia (279): not on OHIP's list (GP26). Office or out-patient clinic only (GP25).
- Allergy shot plus an unrelated problem that needed its own visit (e.g. a chest infection)? Bill the assessment plus G202A per shot, up to 2 (J4). Only a brief check of the allergy itself: use the shot visit G212A instead.
- A623A and A621A share a limit of 4 per 12 months, and A624A is 2 per 12 months; past those OHIP pays a lesser fee, so a complex 3rd visit with a letter is better billed as A621A (GP23–24).
- Spent 20+ minutes in a booked visit only on education (epinephrine, avoidance)? Counselling K013A pays $80.00 per unit, more than A624A, but no assessment is paid that day (GP58).

Allergy shot visit

G212A	Allergy shot was the reason for the visit Includes the first injection and a brief check of the allergic condition (J4).	$12.85
G205A	Insect venom immunotherapy, first injection Per injection, up to 5 a day (J4).	$13.15

- Two vials at a shot-only visit: G212A + one G202A = $20.00. Only 1 G202A is paid on top of G212A (J4).
- G212A already includes a brief assessment of the allergy: don't add A624A or A628A. An unrelated problem that needed its own visit is different: bill that assessment plus G202A (J4).
- Venom shots pay $13.15 each, up to 5 a day. After the initial major assessment, only a partial assessment A628A, once a day, can be added (J4).
- Delegated shots are insured only while you're physically in the office and immediately available; allergy injections aren't on the off-site list (GP62–GP63).
- On a counselling day G202A and G205A are still paid; G212A isn't (GP58).

Testing-only visit

- Skin tests are billed per test: G209A ($0.80) + G197A ($0.39), each to a maximum of 50 a year (J5).
- Venom work-up is one fee, G199A ($40.00), including the skin prick and intradermal tests needed; 2 per patient per physician per 12 months (J5).
- Penicillin testing outside hospital with the minor determinant mixture: G196A + E582A = $49.20. G196A is 3 per patient per physician per 12 months (J5).
- Nasal, ophthalmic and bronchial provocation tests (G201A, G203A, G204A, G207A) are + procedures: add G700A ($8.80) once when they're the only reason for the visit. Skin and patch tests aren't + (J3–J5).
- In a hospital clinic the technical part G209A pays 86.10%, and none is paid for in-patients (GP11).

Food or drug challenge

G208A	Office provocation test (food, additive, drug), first hour Blinded or open. Unit = 1 hour or major part; start and stop times charted (J4, GP7). Limit: 5 sessions per 12 months.	$21.90
G190A	Serial oral or parenteral challenge in hospital Anaphylaxis likely from a documented history; you attend directly and throughout (J5).	$184.95
G185A	Drug desensitisation in hospital Full resuscitation equipment at hand, significant risk of life-threatening anaphylaxis, you attend directly and throughout (J4).	$184.95

- A 3-hour office challenge is 3 units of G208A = $65.70. In hospital, when anaphylaxis is likely, G190A pays $184.95 for the session (J4–J5).
- Respiratory reaction during G208A? Only one pulmonary function test is paid that day (J4).
- G208A and G190A aren't paid on the day you start oral immunotherapy (A620A) (A83).
- The challenge is paid on top of an assessment the same day (J3).

Oral food immunotherapy

A620A	Starting oral food immunotherapy (FAIT) 30+ minutes in person setting the protocol and giving the first doses; you're on site for the whole session. Written protocol (allergens, dosing, risk) in the chart; start and stop times (A83). Limit: Once per allergen per lifetime; once per protocol.	$190.60
K621A	FAIT support visit, per half-hour unit Later in-person visits: assessment, dose changes, counselling, reaction monitoring. Units: 20 min = 1, 46 min = 2 (A84, GP55). Limit: 2 units a day, 12 per 12 months.	$84.20

- A620A pays $190.60, more than a consult ($160.30). It needs IgE-mediated food allergy shown by skin prick, specific IgE or an oral challenge; otherwise it's paid as a lesser fee (A83).
- No other consultation or visit code is paid the same day as A620A or K621A. Plan the consult and the start on different days (A83–A84).
- No G208A or G190A challenge on the A620A day (A83).
- K621A time can be added up over the day, but not overlap another patient's time. A 50-minute updosing visit is 2 units = $168.40 (A84).
- FAIT is in person only: A620A and K621A aren't on the virtual care list (Appendix J).

Called to the ED

A625A	Consultation ED doctor's request on the chart; report back to them.	$160.30
A525A	Limited consultation Narrow question, much less time than a full consult (GP19).	$105.25
A623A	Full assessment, no consult request e.g. your own patient sent in to you.	$95.95
A624A	Re-assessment Your own patient you assessed recently.	$72.00
A628A	Quick look or advice	$44.75

- Not on ED duty when called? Bill your A-code plus the ED special visit premiums (travel and first patient seen). Evenings, weekends and nights pay more (A84, GP65, GP70).
- If you admit the patient, this consult is your admission assessment: as MRP add E082A (+30%) (GP40, GP42).
- Stayed with an unstable anaphylaxis patient? Detention K001A ($21.10 per 15 min) starts after 60 minutes of the consult or assessment (GP29–30).
- No E078A in the ED (GP25).

In-patient consult

C625A	Consultation, routine request Requested by the attending doctor; written report on the chart.	$160.30
C525A	Limited consultation Narrow question, much less time than a full consult.	$105.25
C626A	Repeat consultation Same problem after another doctor's care, new request.	$105.25
C623A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	$95.95
A625A	Called urgently to see another doctor's in-patient Non-elective call to the ward: bill A-prefix codes and the in-patient special visit premiums (A84, GP43).	$160.30

- Urgent call to the ward: bill A625A, not C625A, and add the special visit premiums for the time of day (A84, GP65).
- Drug allergy work-up on the ward: skin tests and G185A desensitisation are paid on top of the consult (J3). G209A's technical part isn't paid for in-patients (GP11).
- Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission (GP42).
- Seen in the ICU or CCU? Add C101A ($9.10) per patient, unless critical care team fees are billed (GP103).

Hospital rounds

C622A	Subsequent visit, first 5 weeks 1 a day. Weeks 6–13: C627A, 3 a week. After week 13: C629A, 6 a month (GP43).	$40.05
C122A	MRP visit, day after admission Once per admission. First visit after transfer out of ICU: C142A instead (GP44, GP46).	$71.80
C123A	MRP visit, 2nd day after admission Once per admission. After an ICU transfer: C143A (GP44, GP46).	$71.80
C124A	MRP, day of discharge Discharge summary within 48 h. Not if the stay was under 48 h (GP45).	$71.80
C126A	MRP, discharge of a complex patient Stay 7+ days, 3+ diagnoses that lengthened it, 45+ minutes of your time. Instead of C124A (A13).	$95.10
C628A	Concurrent care Family doctor stays MRP and asked you to keep directing care: 4 the first week, then 2 a week (GP48).	$40.05

- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays; clinical immunology is on the E084A list. One per patient per day (GP47).
- C122A + E083A = $93.34 versus a plain C622A at $40.05: claim the MRP codes on days 1, 2 and discharge.
- Complex discharge (7+ day stay, 3+ diagnoses, 45+ minutes): C126A pays $95.10, $23.30 more than C124A (A13).
- After week 5, an acute intercurrent illness beyond the weekly limit is C121A ($40.05) (GP43).

Video, phone or e-consult

A624A + K300A	Video re-assessment Full fee. Patient seen in person in the last 24 months, or consulted by video (A66).	$72.00
A624A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85% (A70).	$72.00
A621A + K301A	Phone complex re-assessment, letter to family doctor 85% of $83.40.	$83.40
A625A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	$160.30
K731A	Phone advice to the referring doctor or NP, 10+ min Start and stop times, reason and advice charted. Not to arrange a transfer, visit or test, or mainly to discuss results (A42–A44). Limit: 1 per patient per day.	$47.75
K739A	E-consultation reply through a secure server Opinion sent within 30 days (A48). Limit: 6 per patient per 12 months, 400 a year.	$20.50

- E078A still applies by video or phone for asthma, HIV and lupus patients: 50% of the virtual fee (A74).
- A621A, A623A, A624A and A628A can be by phone or video; consults and in-patient C codes are video only. FAIT codes are in person only (Appendix J).
- Video pays 100%, phone 85%: a video re-assessment is worth $10.80 more than the same call by phone.
- K731A and K739A aren't paid if you see the patient the same day or the next; put the referrer's billing number on the claim (A43, A49).

Also bill, if it's true

E078A	Chronic disease premium (+50%) Established diagnosis on OHIP's list: 493 asthma, 042–044 HIV, 710 lupus, scleroderma or dermatomyositis, 714 RA, and others. Office or out-patient clinic only. That code goes on the claim (GP25–26).	+50%
E082A	I'm admitting as MRP: admission premium +30% of the admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	I'm the MRP, weekday +30% on subsequent visits by the MRP. One of E083A/E084A per patient per day (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A; clinical immunology is an eligible specialty (GP47).	+45%
C101A	Patient is in the ICU or CCU Per patient seen. Not with critical care, ventilatory or comprehensive care team fees (GP103).	$9.10
K001A	Stayed with the patient: detention, per 15 min Active treatment or monitoring, after 60 min of a consult or assessment (40 for a re-assessment, 30 for A628A). Not for waiting (GP29–30).	$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	$80.00
G202A	Allergy shot given at this visit, each Up to 2 when an assessment is paid for the same visit (J4).	$7.15
G202A	Second allergy shot at this visit Only 1 G202A on top of the injection included in G212A (J4).	$7.15
G205A	Each further venom injection today Up to 5 venom injections a day in all (J4).	$13.15
A628A	Also did a partial assessment After the initial major assessment, only a minor or partial assessment, once a day, can go with G205A (J4).	$44.75
G700A	A + test was the only reason for the visit Once per visit when G200A, G201A, G203A, G204A, G207A or the G381A infusion was done. Skin, patch and venom tests and allergy shots aren't + procedures. Not in hospital, not with an assessment (J3–J5, J57).	$8.80
G208A	Each further hour of the office challenge 1 unit per hour or major part; start and stop times charted (J4, GP7).	$21.90
A624A	Also re-assessed the patient Procedures in this section are paid on top of an assessment (J3).	$72.00
A621A	Also did a complex re-assessment, letter to the family doctor Written findings to the primary care physician (GP24, J3).	$83.40
A628A	Also did a quick check Partial assessment (GP25, J3).	$44.75
G489A	Blood draw Adolescent or adult (J7).	$3.54
G372A	IM or SC injection with the visit (not an allergy shot) e.g. epinephrine, a biologic SC dose. Each injection (J54).	$4.55
G590A	Flu shot	$8.80
K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a referral, transfer, visit or test, or mainly to discuss results. Max 1 per patient per day. Paid on top of the visit (A42–A43).	$37.05
K738A	Sent an e-consult to another doctor Secure e-consult service; paid once the other doctor answers within 30 days. 1 a day, 6 per patient per 12 months (A48–A49).	$16.45
K035A	Reported a medical condition to the MTO (driving) Mandatory report. Paid on top of the visit (A59).	$36.25
K036A	Northern health travel grant form Paid to the specialist as well as the referring doctor (A60).	$10.25

K121A	Hospital case conference, per unit Pre-scheduled; the MRP plus 2 other physicians or regulated professionals; 10+ min about this patient. Units: 10, 16, 26, 36 min… Max 4 per patient per 12 months. A visit outside the conference is still paid (A31–A33).	$37.05

Did a test or procedure?

G209A + G197A	Skin prick or intradermal test, per test Technical + professional. Max 50 of each a year (J5).	$1.19
G206A	Patch test, per test Max 90 per patient per year (J4).	$2.39
G198A	Patch test for occupational dermatitis, per test Max 125 per patient per year (J4).	$2.39
G199A	Venom allergy testing All tests needed for venom allergy. 2 per patient per physician per 12 months (J5).	$40.00
G196A	Drug hypersensitivity skin test Validated drugs or agents, not foods or inhalants. 3 per patient per physician per 12 months (J5).	$17.00
G196A + E582A	Penicillin skin test with minor determinant mixture, outside hospital E582A adds $32.20 to G196A (J5).	$49.20
G195A	Local anaesthetic skin test 2 per patient per physician per 12 months (J5).	$17.00
G213A	Physical urticaria challenges At least 3: dermographism, pressure, ice cube, cholinergic exercise, vibration or water, histamine or methacholine (J5).	$13.80
G207A	Bronchial provocative testing, per session Max 6 per year. + procedure (J4).	$14.15
G201A	Direct nasal test, per test Max 3 per year. + procedure (J4).	$1.60
G203A	Direct ophthalmic test, per test Max 3 per year. + procedure (J4).	$1.60
G204A	Quantitative ophthalmic test + procedure (J4).	$12.40
J301B + J301C	Spirometry in your office Best of 3 efforts, written interpretation (H4).	$18.70
J301B + J301C + J324B + J324C	Spirometry before and after bronchodilator (H4).	$26.15
J304B + J304C	Flow volume loop in your office Graphs to scale, your own written interpretation, PFT training on file. Not with J301 the same day (H4).	$34.40
G200A	Acute desensitisation (e.g. ATS, penicillin) + procedure (J4).	$8.65
G389A	Gamma globulin (IVIG) prepared and infused Per patient per day (J55).	$13.90
G381A	Standard IV therapy for autoimmune disease, supervised Biologics only if a monoclonal antibody or cytokine (not IVIG: that is G389A); includes the IV and all assessments for 24 h after. + procedure (J57).	$54.50
G345A	Complex IV biologic for autoimmune disease, supervised Agent that can cause infusion reactions needing immediate intervention, e.g. rituximab (J57).	$75.00
G489A	Blood drawn in your office	$3.54
G373A	IM or SC injection was the only reason for the visit (not an allergy shot) First injection; each more is G372A (J54).	$7.90

Can I bill these together?

Code	With	Together?	Why
A625A,A525A,A626A	A623A, A624A, A621A, A628A	No	Only one consultation or assessment is paid for the same visit (GP10).
E078A	A623A, A624A, A621A, A628A	Yes	E078A adds 50% to a medical specific assessment, re-assessment, complex re-assessment or partial assessment in the office or out-patient clinic, with a listed diagnosis (GP25–26).
E078A	A625A, A525A, A626A, C625A, C623A, C624A, C621A, C622A	No	E078A only adds to office or out-patient assessments, not consultations, in-patient, ED or LTC services (GP25).
A620A	A625A, A525A, A626A, A623A, A624A, A621A, A628A, K621A	No	No other Consultations and Visits service is paid for the same patient on the same day as A620A (A83).
A620A,K621A	K013A, K033A, K002A, K730A, K738A, K035A, K036A, K070A	No	These are listed in the Consultations and Visits section, and no other service from that section is paid the same day as A620A or K621A (A83–A84).
A620A	G208A, G190A	No	Provocation testing G208A and G190A isn't paid on the same day as A620A (A83).
K621A	A625A, A525A, A626A, A623A, A624A, A621A, A628A	No	No other Consultations and Visits service is paid for the same patient on the same day as K621A (A84).
G209A,G197A,G206A,G198A,G199A,G196A,G195A,G213A	A625A, A525A, A626A, A623A, A624A, A621A, A628A	Yes	Diagnostic procedures are paid on top of a consultation or assessment (J3).
G212A	A625A, A623A, A624A, A621A, A628A	No	G212A includes a brief assessment of the allergic condition. For an unrelated problem that needed its own visit, bill the assessment plus G202A instead (J4).
G212A	G202A	Yes	One G202A is paid on top of the injection included in G212A (J4).
G202A	A623A, A624A, A621A, A628A	Sometimes	Paid with an assessment for an acute or unrelated problem, up to 2 injections (J4).
G205A	A628A	Sometimes	After the initial major assessment, only a minor or partial assessment, once a day, is paid with venom immunotherapy (J4).
G205A	A623A, A624A, A621A	Sometimes	With G205A a major assessment is paid only at the initial visit; after that only a partial assessment (J4).
G208A	J301, J304, J324, J327, G207A	Sometimes	If the reaction to G208A is respiratory, only one pulmonary function test is paid that day (J4).
G196A	E582A	Yes	E582A adds to G196A when testing with penicillin minor determinant mixture outside a hospital (J5).
G199A	G209A, G197A	Sometimes	Only for skin tests to something other than venom: G199A already includes the skin prick and intracutaneous tests of the venom work-up (J5).
G700A	G200A, G201A, G203A, G204A, G207A, G381A	Yes	These are + procedures: add G700A once when one is the only reason for the visit, outside hospital (J3).
G700A	G209A, G197A, G206A, G199A, G196A, G212A, G202A, G205A	Sometimes	These aren't + procedures, so G700A needs a + test (G200A, G201A, G203A, G204A, G207A) as the sole reason for the visit (J3–J5).
G700A	A625A, A525A, A626A, A623A, A624A, A621A, A628A	No	G700A is for a visit where a + procedure was the sole reason, not with a consultation or assessment (J3).
G381A,G345A	A623A, A624A, A621A, A628A, C622A	Sometimes	An assessment before the infusion is paid (J3); assessments by any physician in the 24 hours after it are included (J57).
G381A,G345A	G489A	No	Venipuncture and the IV line are included in the infusion fee (J57).

Code	With	Together?	Why
J301,J324	J304, J327	No	Spirometry isn't paid the same day as a flow-volume loop (H4).
G373A	A625A, A623A, A624A, A621A, A628A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A (J54).
K013A,K033A	A625A, A525A, A626A, A623A, A624A, A621A, A628A	No	With counselling no consultation or assessment is paid the same day (GP58).
K013A,K033A	G202A, G205A, G489A, G372A, G590A, K002A, K035A, K036A, K730A	Yes	These are on the list of services allowed with counselling (GP58).
K013A,K033A	G212A, G209A, G197A, G208A, K738A	No	With counselling only the services listed in GP58 are paid the same day; this isn't one of them (GP58).
K002A	A625A, A623A, A624A, A621A, A628A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A,K739A	A625A, A623A, A624A, A621A, A628A, C625A, K013A	No	Phone or e-consult isn't paid if you see the patient the same day or the next day; bill the visit (A43, A49).
K730A,K738A,K035A, K036A	A625A, A525A, A626A, A623A, A624A, A621A, A628A	Yes	Paid on top of the visit: K730A and K738A in addition to visits the same day (A42, A48), K035A and K036A have no same-day rule (A59–A60).
K121A	C625A, C623A, C624A, C622A, C122A, C123A, C124A, C126A, C628A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C628A, C625A, C623A	No	E083A/E084A only add to subsequent visits by the MRP, not consults or concurrent care (GP47–48).
E082A	C622A, C122A, C123A, C124A, C126A, E083A	No	E082A only adds to the MRP's admission assessment and no other service or premium (GP42).
C122A,C123A,C142A, C143A	C124A, C126A	No	C122A/C123A/C142A/C143A aren't paid the same day as the discharge visit (GP44, GP46).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
K001A	A625A, A623A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–30).

From the Ontario Schedule of Benefits (effective July 1, 2026): Clinical Immunology listings A83–A85 (including FAIT, A620A and K621A), General Preamble GP10–GP103, Diagnostic and Therapeutic Procedures (Allergy J4–J5, J53–J57) and Pulmonary Function Studies (H4). Clinical immunology has no long-term care listing; the Schedule sends you to Internal Medicine for services it doesn't list (A83). Totals leave out the age premium on specialist consultations for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance. Skin test technical fees in a hospital clinic are paid at 86.10% (GP11); the totals show the full fee. Phone visits are shown at the 85% OHIP pays; E078A on a virtual visit is 50% of the virtual fee. Check your remittance advice if a fee looks different.

Fees are the Ontario Schedule of Benefits amounts and may change. Billing codes, rules and rejections for every code: verismo-apex.com/resources/billing.