Community Medicine OHIP Billing Cheat Sheet 2026

OHIP specialty 05 · Immunization or injection visit · Long-term care: admission or yearly exam · Long-term care: subsequent visit · Updated November 2026

Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/community-medicine

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

Office consultation

A055A	Consultation Written, signed referral naming you, the referrer's billing number and the patient's health number; written report back (GP16).	$152.80
A050A	Special consultation, 50+ min All consult elements plus 50+ minutes face to face, not counting other billable services or chart review. Start and stop times in the chart (A86).	$176.10
A400A	Comprehensive consultation, 75+ min All consult elements plus 75+ minutes face to face. Start and stop times in the chart (A86).	$270.60
A405A	Limited consultation Referral needs substantially less time than a full consult (GP19).	$94.75
A056A	Repeat consultation Same problem, new written referral, and another doctor treated the patient since your consult (GP19).	$94.75

- Time decides the code: 50+ minutes face to face is A050A ($176.10), 75+ minutes is A400A ($270.60), against $152.80 for A055A (A86).
- No start and stop times charted: A050A and A400A drop to a lesser fee (A86).
- One consult per patient per diagnosis per 2 consecutive 12-month periods, including A050A and A400A; repeat consults don't count (GP17–18).
- Detention K001A starts after 60 minutes for A055A, 90 for A050A and 120 for A400A; IC claim with a written explanation (GP30–31).
- No written, signed referral in the chart: OHIP pays it as an assessment (GP16).

Follow-up visit

A054A	Medical specific re-assessment Full relevant history and exam of one or more systems. Limit: 2 per patient per 12 months (GP23).	$64.30
A051A	Complex re-assessment Complex, obscure or serious condition. Written findings must go to the primary care physician (GP24). Limit: 4 per 12 months, combined with A053A (GP24).	$74.45
A053A	Medical specific assessment Full history of the complaint and detailed exam of the affected systems; new problem, no referral. Limit: 1 per 12 months (2 for a clearly different diagnosis) (GP23).	$83.85
A058A	Partial assessment History of the complaint, the exam needed, advice, record. No yearly limit (GP25).	$39.95

- Serious or complex problem and a written note to the family doctor? A051A pays $74.45 instead of $64.30 (GP24).
- Over a limit, OHIP pays a lesser assessment: A054A 2 per 12 months, A053A 1 (2 for a clearly different diagnosis), A053A + A051A together 4 (GP23–24). Past those, bill A058A.
- The chronic disease premium E078A is not payable to Community Medicine (GP25).
- Phoned or e-consulted another physician about the patient? K730A or K738A is paid on top of the visit (A42, A48).

Immunization or injection visit

- Immunization was the only reason for the visit? Add G700A ($8.80) once per patient per day (J54).
- No G700A when you also bill a consult or assessment that day, or in hospital (J3).
- Given by a nurse employed by the public health unit, hospital or other organization, not by you? Delegated injections and immunizations are only paid when the person is your own employee (GP63).
- Immunizations may be billed the same day as counselling (K013A), unlike most other services (GP58).

Hospital in-patient consult

C055A	Consultation, routine request Seen on your own schedule (A86).	$152.80
C050A	Special consultation, 50+ min Same conditions as A050A: start and stop times charted (A86).	$176.10
C400A	Comprehensive consultation, 75+ min Same conditions as A400A (A86).	$270.60
C405A	Limited consultation Narrower question, substantially less time (A87).	$94.75
C053A	Medical specific assessment In-patient, no consult request (A87).	$83.85
A055A	Called in urgently to see another doctor's patient Non-elective call: bill the General Listing with special visit premiums (A86, GP43).	$152.80

- Emergency calls to the ward use A055A plus the in-patient special visit premiums, not C055A. Chart the time of the visit (A86, GP69).
- Admitting the patient yourself as most responsible physician? Your consult or assessment is the admission assessment: add E082A (+30%), once per admission, not for transfers within the hospital (GP40, GP42).
- Other in-patient codes: C056A repeat consult $94.75, C054A re-assessment $64.30, C051A complex re-assessment $74.45 (A87).
- Seen in ICU or CCU? Add C101A ($9.10) per patient (GP103).

Hospital follow-up (rounds)

C052A	Subsequent visit, first 5 weeks 1 per day. Weeks 6–13: C057A (3 per week). After week 13: C059A (6 per month) (A87, GP43).	$40.05
C122A	You're MRP: day after admission Once per admission; C142A instead if the day after transfer out of ICU (GP44, GP46).	$71.80
C123A	You're MRP: second day after admission Once per admission; C143A instead after an ICU transfer (GP44).	$71.80
C124A	You're MRP: day of discharge Stay 48+ hours, discharge summary within 48 hours, follow-up and discharge meds arranged (GP45).	$71.80
C126A	You're MRP: complex discharge Stay 7+ days, 3+ diagnoses that lengthened it, 45+ min on the discharge (A13).	$95.10
C058A	Concurrent care MRP asked you to keep directing care: 4 in the first week, then 2 per week (GP48).	$40.05

- MRP? Every subsequent visit gets E083A (+30%). The weekend and holiday E084A (+45%) is not payable to Community Medicine (GP47).
- MRP day-after-admission and second-day visits pay $71.80, not $40.05 (GP44).
- After week 5, an acute intercurrent illness beyond the limits is C121A ($40.05) (GP43).
- Palliative care visit: C982A ($40.05), E083A applies when you're MRP (A87, GP47).

Long-term care: admission or yearly exam

W402A	Admission assessment, Type 1 General assessment on admission, when you had not given a consultation, general assessment or general re-assessment before admission (GP49).	$69.35
W404A	Admission assessment, Type 2 First visit after admission when you gave a consultation, general assessment or general re-assessment before admission (GP49).	$20.60
W407A	Admission assessment, Type 3 Re-admission after a stay of 3+ days in another institution (GP49).	$30.70
W409A	Periodic health visit (A88).	$65.05
W054A	Nursing home general re-assessment Per the Nursing Homes Act (A88). Limit: Only 6 months after the periodic health visit (A88).	$20.60

- Consulted the resident before admission? Type 1 is cut to a lesser fee: bill Type 2, W404A (GP49).
- W054A is only claimed 6 months after the periodic health visit W409A (A88).
- Special visit premiums are not paid for residents seen on rounds (GP65).

Long-term care: subsequent visit

W053A	Nursing home or home for the aged: first 2 visits this month (A88).	$40.05
W058A	Nursing home: additional visit (A88). Limit: Max 3 per patient per month (A88).	$40.05
W052A	Chronic care or convalescent hospital: first 4 visits this month (A88).	$40.05
W051A	Chronic care: additional visit (A88). Limit: Max 6 per patient per month (A88).	$40.05
W121A	Acute intercurrent illness Paid whenever rendered, whether or not the monthly limit is reached (GP49).	$40.05
W124A	Day of discharge Stay 30+ days, discharged to another facility or home with care taken over by another provider; discharge summary with follow-up. Not for respite (A20, A88).	$71.80

- Monthly limits run per patient: nursing home 2 + 3 additional, chronic care 4 + 6 additional (A88).
- Beyond the limits for an acute illness, bill W121A instead of a subsequent visit (GP49).
- Called urgently to see another physician's resident: bill the A-prefix General Listing with long-term care special visit premiums (GP49).
- Palliative care visits: W972A nursing home, W982A chronic care, $40.05 each (A88).

Long-term care consultation

W055A	Consultation Resident of a chronic care or convalescent hospital, nursing home or home for the aged (A87).	$152.80
W050A	Special consultation, 50+ min Same conditions as A050A (A87).	$176.10
W400A	Comprehensive consultation, 75+ min Same conditions as A400A (A87).	$270.60
W405A	Limited consultation (A87).	$94.75
W056A	Repeat consultation (A87).	$94.75
A055A	Called in urgently Emergency call or other special visit: General Listing plus long-term care premiums (A87, GP49).	$152.80

- Start and stop times are needed for W050A and W400A too, as for A050A and A400A (A86–A87).
- Non-elective call to the facility: A055A with travel and first-person premiums, not W055A (A87, GP49).

Video, phone or e-consult

A054A + K300A	Video follow-up Patient you've seen in person in the last 24 months, or consulted by video. Full fee (A66).	$64.30
A054A + K301A	Phone follow-up Phone pays 85% of the in-person fee (AJ1).	$64.30
A051A + K301A	Phone complex re-assessment Written report to the primary care physician still required (GP24).	$74.45
A055A + K300A	Video consultation Consultations are video only, never phone (AJ2).	$152.80
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit or transfer, and not mainly about results (A42–A43).	$47.75
K739A	e-Consult reply Opinion through a secure server within 30 days. Max 6 per patient per 12 months, 400 a year (A48).	$20.50

- A055A, A050A, A400A, A405A and A056A are video only; A053A, A054A, A051A and A058A can be video or phone (AJ1–AJ2).
- K731A and K739A aren't paid if you see the patient that day or the next (A43, A49).
- The patient has to start the contact (or it's a needed follow-up of one). A check-in call you start isn't billable (A68).

Also bill, if it's true

E082A	You admitted them as MRP (+30%) This consult is your admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	You're the MRP (+30%) Subsequent visit as most responsible physician (GP47).	+30%
C101A	Patient seen in ICU or CCU Not with critical care, ventilatory or comprehensive care team fees (GP103).	$9.10
G700A	Immunization or + procedure was the only reason for the visit Once per patient per day. Not in hospital, not with a consult or assessment (J3, J54).	$8.80
K036A	Northern Health Travel Grant form Paid to the referring physician and the specialist (A60).	$10.25
K730A	Phoned another physician for advice 10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test, or mainly about results. 1 a day. Paid on top of the visit (A42–A43).	$37.05
K738A	Sent an e-consult to another physician Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months. Paid on top of the visit (A48).	$16.45

Gave a vaccine or did a procedure?

G590A	Influenza vaccine (J54).	$8.80
G593A	COVID-19 vaccine (J54).	$13.00
G849A	RSV vaccine (J54).	$8.80
G847A	Tdap, adult (J54).	$8.80
G842A	Hepatitis B vaccine (J54).	$8.80
G843A	HPV vaccine (J54).	$8.80
G845A	MMR vaccine (J54).	$8.80
G848A	Varicella vaccine (J54).	$8.80
G846A	Pneumococcal conjugate vaccine (J54).	$8.80
G844A	Meningococcal C conjugate vaccine (J54).	$8.80
G538A	Other immunizing agent Not listed above (J54).	$8.80
G369A	BCG inoculation after tuberculin tests (J53).	$5.30
G372A	IM or SC injection with a visit Each injection (J54).	$4.55
G373A	IM or SC injection was the only reason for the visit First injection; more are G372A (J54).	$7.90
G489A	Blood drawn Adolescent or adult (J7).	$3.54
G009A	Urinalysis with microscopy, in your office Result, interpretation and treatment decision charted (J65, J68).	$4.90
G010A	Urine dipstick only, in your office (J65, J68).	$2.64
G005A	Pregnancy test, in your office Only when an immediate answer is needed to prevent imminent harm (J67).	$3.88

Can I bill these together?

Code	With	Together?	Why
A055A,A050A,A400A,A405A,A056A	A053A, A054A, A051A, A058A	No	Only one consultation or assessment is paid for the same visit (GP10).
A055A	A050A, A400A	No	Only one consultation is paid for the same visit; pick the one your face-to-face time supports (GP10, A86).
E078A	A053A, A054A, A051A, A058A	No	Community Medicine (05) is not on the list of specialties that can bill E078A (GP25).
E083A	C052A, C122A, C123A, C124A, C126A, C121A, C982A	Yes	E083A adds 30% to the MRP's subsequent and palliative care visits (GP47).
E084A	C052A, C122A, C123A, C124A, C126A	No	E084A is only paid to MRPs in the listed specialties; Community Medicine (05) isn't one (GP47).
E083A	C058A, C055A, C053A	No	E083A only adds to subsequent visits by the MRP, not consults or concurrent care (GP47).
E082A	C052A, C122A, C123A, C124A, C126A, E083A	No	E082A only adds to the MRP's admission assessment and no other service or premium (GP42).
C122A,C123A	C124A, C126A	No	C122A and C123A aren't paid the same day as a discharge visit (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
W402A	W055A, W050A, W400A, W405A, W056A, A055A, A050A, A400A	Sometimes	If you gave the resident a consultation before admission, Type 1 is cut to a lesser fee: bill W404A (GP49).
W054A	W409A	Sometimes	W054A may only be claimed 6 months after the periodic health visit (A88).
K731A,K739A	A055A, A050A, A400A, A405A, A056A, A053A, A054A, A051A, A058A, C055A, C052A	No	Not paid when the consultant sees the patient (consult, assessment, visit or K time code) the same day or the next day (A43, A49).
K730A,K738A,K036A	A055A, A050A, A400A, A053A, A054A, A051A, A058A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K730A and K738A in addition to visits the same day (A42, A48).
K013A,K033A	A055A, A050A, A400A, A053A, A054A, A051A, A058A	No	No consult or assessment is paid the same day as counselling by the same physician (GP58).
K013A,K033A	G590A, G593A, G538A, G840A, G841A, G842A, G843A, G844A, G845A, G846A, G847A, G848A, G849A, G372A, G489A, K036A	Yes	These are on the list of services still paid the same day as counselling (GP58).
G700A	G590A, G593A, G538A, G840A, G841A, G842A, G843A, G844A, G845A, G846A, G847A, G848A, G849A, G369A	Yes	Immunization or another + procedure was the sole reason for the visit: add G700A once per patient per day (J3, J54).
G700A	A055A, A050A, A400A, A405A, A056A, A053A, A054A, A051A, A058A	No	G700A is not paid when a consultation or assessment is payable the same day (J3).

Code	With	Together?	Why
G590A,G593A,G538A,G842A,G847A,G849A	A053A, A054A, A051A, A058A, A055A	Yes	Procedures in the D&T section are paid in addition to a consultation or assessment (J3).
G373A	A055A, A050A, A400A, A053A, A054A, A051A, A058A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A (J54).
G373A	G372A	Yes	Sole-reason visit: the first injection is G373A and each additional injection G372A (J54).
K001A	A055A, C055A	Sometimes	Detention starts after 60 minutes of the consultation; IC with a written explanation (GP30–31).
K001A	A050A, C050A	Sometimes	Detention after a special community medicine consultation starts after 90 minutes (GP30).
K001A	A400A, C400A	Sometimes	Detention after a comprehensive community medicine consultation starts after 120 minutes (GP31).

From the Ontario Schedule of Benefits (effective July 1, 2026): Community Medicine pages A86–A88, the General Preamble, Diagnostic & Therapeutic Procedures (J3, J53–J54, J65–J68) and Appendix J. Community Medicine can't bill the chronic disease premium E078A (GP25) or the weekend MRP premium E084A (GP47). Examinations for a research or survey program are not insured (GP8). OHIP adds age premiums on the remittance (GP64: +10% to +30% on specialist consultations for patients under 16), so they are not in these totals. Phone amounts assume OHIP's 85% rate. 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.