

Family Practice OHIP Billing Cheat Sheet 2026

OHIP specialty 00 · Visits, physicals, counselling, FHO/FHG/CCM premiums · Updated October 2026

Interactive version: <https://verismo-apex.com/resources/ohip-billing-cheatsheet/family-practice>

Problem visit

A001A	Quick look or advice Brief look at one area, or advice, a renewal, a result explained.	\$26.80
A007A	History and exam of the problem Asked about the problem and examined the area enough to make a diagnosis.	\$44.55
K039A	Quit-smoking follow-up visit Within 12 months after your E079A. Up to 2. Also assessed a problem? Tick it below: K039A isn't an assessment, so both are paid.	\$39.25
Q888A	Unscheduled weekend or holiday visit Enrolled patient seen without a booking on a Saturday, Sunday or holiday. In place of A007A (agreement lists \$37.95).	\$44.55
A003A	Full check of everything Full history (family, past, social, every system) and examined every body system.	\$95.60

- A003A is once per patient per 12 months, or twice when the second is for a clearly different, unrelated problem (GP21).
- Did the quit-smoking follow-up in the same visit as an A007A? K039A isn't an assessment, so bill A007A + K039A, plus Q042A for an enrolled patient in FHO, FHG or CCM. With a physical, prenatal, home or long-term care visit, tick it on that visit, or pick the quit-smoking follow-up and tick the visit under it.
- A004A (re-assessment) pays less than A007A. Bill A007A instead.
- Patient here about their diabetes? Pick Diabetes check: K030A pays more.
- Spent 20+ minutes counselling or on mental health? Pick Mental health, or Counselling or interview: \$80 per 20 minutes.
- Also treated a separate mental health problem for 20+ minutes? Tick K005A above: it's payable with the assessment when the diagnoses are clearly different.
- E078A (the specialists' chronic disease premium) isn't payable to family physicians: GP25 limits it to certain specialties. Family practice claims with it come back rejected (A3F or V30).

Annual physical

A007A	Baby, under 2: well baby visit Full exam, weight and measurements, advice to parents.	\$44.55
A002A	Baby, 17–24 months: 18-month visit with developmental screen Well baby care plus the 18-month screen and a parent questionnaire such as NDDS.	\$73.95
K017A	Child, 2 to 11	\$49.55
K130A	Teen, 12 to 17	\$87.10
K131A	Adult, 18 to 64	\$64.25
K132A	Adult, 65 or older	\$91.35

- Only for a patient with no acute problem. Once a year per patient from age 2. Under 2, well baby visits follow the visit schedule: OHIP allows up to 10 before the 2nd birthday (RA code R2).
- Patient with an intellectual or developmental disability, 50+ minute visit with a care plan: bill K133A (\$164.25) instead.

Mental health

K005A	Mental health care Depression, anxiety and other mental health problems. No yearly unit limit.	\$80.00
K007A	Psychotherapy Structured therapy.	\$80.00

- 20 minutes of mental health care pays \$80.00, almost double an A007A (\$44.55).
- K005A or K007A can go with A001A, A007A or A003A the same day when the assessment is for a clearly different diagnosis (GP55). Put 300 on the K005A and the other problem's code on the assessment.
- Count face-to-face time in one stretch: 20 min = 1 unit, 46 = 2, 76 = 3. Under 20 minutes, bill A007A.
- By phone, K005A and K007A pay 95% instead of 85%.
- Shots and injections are paid on top of K005A or K007A; the time they take doesn't count toward the units (GP55).

Counselling or interview

K013A	Counselling or education Booked visit only for advice and education about a problem, prevention or treatment. First 3 units per patient per year, then K033A.	\$80.00
K002A	Interview with relatives or substitute decision-maker About the patient's care, not only to get consent. Billed on the patient's health number.	\$80.00
K003A	Interview with Children's Aid Society or legal guardian For a purpose other than consent. Billed on the patient's health number.	\$80.00
K008A	Interview or counselling with a child and/or parent For a psychological problem or learning disability. Billed on the child's health number.	\$80.00
K015A	Counselling relatives of a terminally ill patient Billed on the ill patient's health number.	\$80.00

- 20 minutes of counselling pays \$80.00, almost double an A007A (\$44.55). Even K033A (\$56.30) pays more than A007A.
- Counselling and interviews must be booked as their own appointment, or OHIP pays them as a lesser assessment (GP58, GP61).
- An interview can't be the history-taking for a visit; it's a separate 20+ minute meeting (GP61).
- With counselling, don't bill an assessment the same day. Shots, injections, blood draws, the Pap specimen and interviews are allowed (GP58).

Diabetes check

K030A	Yes, flow sheet updated Up to 4 a year. Don't bill A007A the same day.	\$45.75
A007A	No flow sheet Bill it as a normal problem visit.	\$44.55

- FHO: K030A is paid in full; A007A is paid at 30%. Always keep the flow sheet.
- E078A (the specialists' chronic disease premium) isn't payable to family physicians: GP25 limits it to certain specialties. Family practice claims with it come back rejected (A3F or V30).
- After the 3rd K030A in a year, add Q040A (\$65.70) once the yearly checks are done.

Pregnancy

P003A	First prenatal visit	\$93.85
P004A	Follow-up prenatal visit	\$44.55
P008A	Postnatal visit in the office	\$43.80

- Bill P codes, not A007A, for every prenatal visit. FHO: they're paid in full.

Baby check (under 2)

A007A	Well baby visit Full exam, weight and measurements, advice to parents.	\$44.55
A002A	18-month visit with developmental screen Age 17–24 months. Screen plus a parent questionnaire such as NDDS.	\$73.95

- Each routine vaccine is billed separately (G840A, G841A, G845A, G846A, G848A and others).

Shot or procedure only

- If you also assessed a new problem, pick Problem visit instead and add the procedure there.
- G700A only goes with procedures marked (+) in the Schedule: vaccines, the Pap specimen, joint injection, ear syringing and the Epley manoeuvre. Injections, IUDs, trigger points, skin procedures, ECG and spirometry don't take it (J3).
- Procedures done at the visit where you decided to treat are paid on top of the assessment.

Home visit

A007A	Regular home visit No travel premiums with A007A at home.	\$44.55
A900A + B960A + B990A	Frail elderly or housebound patient 65+ with complex meds, memory problems, falls or decline, or can't get to the office.	\$130.45
A007A + B966A + B998A	Palliative care patient Night visit (00–07): B997A instead of B998A, \$113.10.	\$173.75

- A900A is what unlocks the travel and visit premiums. Write down why the patient is frail or housebound.
- Urgent home calls in the evening, on weekends or at night pay higher premiums (B994A, B993A, B996A).

Hospital in-patient

C002A	Daily visit, first 5 weeks Routine visit to your in-patient. 1 per patient per day for the first 5 weeks after admission (GP43).	\$40.05
C122A	Day after admission, you're the MRP Once per admission. Not with C124A or C126A the same day, and only one of C122A or C142A per admission (GP44).	\$71.80
C123A	Second day after admission, you're the MRP Once per admission. Only one of C123A or C143A per admission (GP44).	\$71.80
C124A	Discharge day, you're the MRP Includes the discharge summary within 48 hours (reason, procedures, diagnosis, medications). Not if discharged within 48 hours of admission (GP45).	\$71.80
C126A	Discharge day, medically complex patient 7+ day stay, 3+ diagnoses behind the stay, 45+ minutes. One of C124A or C126A per admission (A13).	\$95.10
C003A	Admission: full assessment Not seen for this illness in the last 90 days. Seen for it within 90 days: C004A re-assessment (\$38.35) (GP40).	\$89.65
C933A	Admission as the on-call doctor You're on the hospital's on-call roster and become the MRP for a non-elective admission. First per patient per 30 days (A7).	\$82.00
C007A	Visit in weeks 6–13 Up to 3 per patient per week (GP43).	\$40.05
C009A	Visit after week 13 Up to 6 per patient per month (GP43).	\$40.05
C121A	Extra visit for a new acute illness, after week 5 Outside the weekly and monthly limits (GP43).	\$40.05
C142A	First visit after transfer out of the ICU, you're the MRP Patient got critical care, ventilation or comprehensive care in the ICU just before transfer. C143A (\$71.80) for the second visit. Once each per admission (GP46).	\$71.80

- Called in from outside to see another doctor's patient urgently? Bill the A-prefix assessment with the hospital special visit premiums, not a C code (GP43, GP72).
- Concurrent care (C008A) and supportive care (C010A) are \$40.05 visits when you follow the patient alongside the MRP (A13).
- C122A–C124A, C002A, C007A, C009A, C142A, C143A and E082A–E084A count toward the FHO hospital services bonus (FHO agreement Schedule 3).
- Hospitalist premium: 1,500+ qualifying in-patient services on 110+ days last year adds 17% to C002A, C007A, C009A, C122A–C126A, C142A, C143A, C933A and C882A for 12 months (GP103).

Long-term care

W010A	Monthly management, nursing home patient You're the MRP and saw the patient at least twice this month. Covers routine visits, the yearly physical, staff calls, medication reviews and more (GP51).	\$135.30
W003A	Nursing home visit First 2 per patient per month. Then W008A (\$40.05), up to 2 more. Not in a W010A month (A19, GP51).	\$40.05
W102A	Admission assessment, new to you (Type 1) General assessment on admission. Did a consultation or general assessment just before admission? Then W104A (Type 2, \$20.60). Readmission after 3+ days elsewhere: W107A (Type 3, \$30.70) (GP49).	\$71.20
W109A	Yearly physical Periodic health visit in long-term care. W004A re-assessment (\$38.35) 6 months later (A19).	\$72.35
W002A	Chronic care or convalescent hospital visit First 4 per patient per month. Then W001A (\$40.05), up to 4 more (A19).	\$40.05
W121A	Extra visit for a new acute illness Payable regardless of the monthly limits; needing a special visit instead? Use the A-prefix code with the premiums (GP49).	\$40.05
W124A	Discharge day 30+ day stay, discharged home or elsewhere to another provider's care, with follow-up in the discharge summary. Not for respite (A20).	\$71.80

- W010A already includes that month's W003A, W008A, W102A, W104A, W107A, W109A, W004A and W872A by any doctor, W121A too unless you made 5+ W visits that month (GP52), W777A and W771A unless part of a special visit, plus K070A–K072A, routine shots and office lab tests

(GP51). Pick W010A or the separate visits, not both.

- Calls from the staff on weekdays 07–17 are part of W010A; urgent visits outside that are billed with the long-term care special visit premiums (GP51, GP73).
- Consultation in long-term care: W105A (\$95.60), repeat W106A (\$45.90); special and comprehensive W911A/W912A as in the office (A19).

Palliative care

K023A	20+ min of palliative support Pain and symptom management, emotional support or counselling, in any setting. Bill it instead of the visit code. Chart start and stop times.	\$85.25
K015A	Met the family about the patient's care or prognosis Booked meeting with relatives. Billed on the patient's health number; no assessment by you that day.	\$80.00
A945A	Special palliative consultation, 50+ min Another doctor or nurse practitioner asked for it; send them a report. Includes psychosocial assessment, medication review and community services. Under 50 min: a regular consultation (A005A, C005A, W105A).	\$174.25
C945A	Special palliative consultation, your hospital in-patient, 50+ min Same rules as A945A, on the ward without a special visit. Called in from outside? Pick A945A and Called in to the hospital.	\$174.25
C882A	Hospital visit, under 20 min You're the most responsible physician. Also for a designated palliative care bed in any facility. Specialists bill C982A.	\$40.05
W872A	Nursing home visit, under 20 min You're the most responsible physician. Not in a month you bill W010A for this patient. Specialists bill W972A.	\$40.05
W882A	Chronic care or convalescent hospital visit, under 20 min You're the most responsible physician. Specialists bill W982A.	\$40.05
G512A	Weekly case management You're the most responsible physician: monitoring, tests, calls with the family, arranging care. Once per patient per week (Mon–Sun), any setting.	\$67.75
G511A	Phone advice, patient at home The patient or family called you. Up to 2 a week, not on a day you saw the patient, not in a G512A week. Chart a dated note.	\$18.20
K071A	Advised home care staff, first 8 weeks Ontario Health atHome staff; chart the advice and the staff member's name. 1 a week per doctor. Not on a day you saw the patient, not in a G512A week.	\$21.95
K072A	Advised home care staff, after week 8 Up to 2 a month per doctor. Not on a day you saw the patient, not in a G512A week.	\$21.95
A902A	Pronounced death Includes the death certificate and talking with the family. Use the underlying cause of death as the diagnosis.	\$64.80
A771A	Death certificate only Someone else pronounced the death (another doctor, a resident or a nurse).	\$24.20
K700A	Case conference Booked meeting about this patient with 2+ other providers (doctors, social workers or other regulated professionals), in person, by video or by phone. Chart start and stop times and who attended. Up to 4 a year per patient.	\$37.05
K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a transfer, a visit or a test, or mainly to discuss results; not if they see the patient that day or the next. On duty in the ED: K734A. The doctor who advises bills K731A (\$47.75).	\$37.05
K738A	Sent an e-consult Through a secure e-consult service; paid once the other doctor answers within 30 days. The doctor who answers bills K739A (\$20.50).	\$16.45

- Palliative care means a terminally ill patient in the final year of life, with care aimed at comfort, not treating the disease (GP5). Any terminal illness counts, not only cancer.
- K023A replaces the visit code: nothing else from the Family Practice section goes with it (visits, the K070A home care form, case conferences, phone consults), except A945A or C945A (A2). 20 min = 1 unit, 46 = 2, 76 = 3. Under 20 minutes, bill the visit code instead.
- Home visits: B966A + B998A pay at any hour with no daily maximum and no need to leave booked patients (GP76). They go with K023A, A007A, A900A or A945A.
- Called in to a hospital or long-term care patient: bill the A-prefix code (A007A, A945A, A777A) or K023A, plus the C or W travel and person premiums. Not for patients you see on rounds (GP65). Up to 2 travel premiums and 10 patients per period on weekdays and evenings, 6 and 20 on weekends; no limit at night.

- G512A week: nobody can bill G511A, K071A or K072A for the patient that week. Visits, K023A, K070A and W010A still pay (J102).
- Death: at home A902A; in hospital C777A; in long-term care W777A; called in on a special visit, A777A with the premiums. Certificate only: A771A, C771A or W771A (\$24.20). The certificate is \$0 when you also pronounced.
- A case conference (K700A) and a visit the same day are both paid, as long as the visit isn't during the conference (A32). No phone consult (K730A) that day (A33).
- Hospital in-patients: as the most responsible physician, C122A and C123A (\$71.80) on the 2 days after admission and C124A on the discharge day (not if the patient died). E082A adds 30% to your admission assessment.
- Yearly palliative care premium: 4+ patients a year with K023A, C882A, A945A, C945A, W882A, W872A, B997A or B998A pays \$2,400; 10+ pays \$6,000 in total (FHO agreement S8.6). The OMA guide opens the \$2,400 level to every family physician and the \$6,000 level to patient enrolment models only.
- FHO: A945A, K023A, the B966A/B997A/B998A premiums, G511A and G512A are outside the basket and paid in full. C882A, W872A, W882A and K015A are in the basket.
- By video (K300A) K023A, K015A and A945A pay in full; by phone (K301A) K023A and K015A pay 85%. A945A isn't payable by phone. New to you: A101A or A102A.

Phone or video

A007A + K300A	Video, patient you know Seen in person in the last 2 years, or enrolled with your group. Full fee.	\$44.55
A007A + K301A	Phone, patient you know Phone pays 85% (95% for K005A and K007A).	\$37.87
K039A + K300A	Quit-smoking follow-up by video Within 12 months after your E079A, up to 2. Full fee (Appendix J).	\$39.25
K039A + K301A	Quit-smoking follow-up by phone Within 12 months after your E079A, up to 2. Phone pays 85%.	\$33.36
A101A	Video, new to you	\$20.00
A102A	Phone, new to you	\$15.00

- The patient has to ask for the call. A check-in call you start isn't billable.
- Write in the note whether it was phone or video.

Also bill, if it's true

E079A	Smoker: first talk about quitting this year Once a year. Tobacco only, not vaping.	\$15.95
K039A	Also did the quit-smoking follow-up Within 12 months after your E079A, up to 2. K039A isn't an assessment, so it's paid on top of the visit. Chart it on a CTI flow sheet. Tobacco only, not vaping.	\$39.25
A007A	Also assessed a problem History and exam of a problem. K039A isn't an assessment (GP15), so A007A is paid on top. Use the problem's own diagnostic code on the A007A.	\$44.55
A003A	Also did a full check of everything Full history and exam of every system. Once per patient per 12 months (GP21); otherwise tick A007A. Paid on top of K039A.	\$95.60
A001A	Also handled a different problem briefly Only for a different problem: advice on staying healthy is part of A001A itself (GP27). Paid on top of K039A.	\$26.80
E080A	First visit within 14 days of a hospital discharge Acute-care admission, not day surgery or a routine delivery.	\$25.90
E080A	First visit within 14 days of the baby's NICU discharge Only when the newborn was admitted to a neonatal ICU; not after routine newborn care (GP28).	\$25.90
G365A + E430A	Pap / HPV screen Age 25+, none in the last 33 months.	\$23.95
E430A	Pap / HPV screen Age 25+. With this visit only the add-on is paid.	\$11.95
G365A	Pap / HPV screen Age 25+, none in the last 33 months. With counselling only G365A is paid: the E430A add-on isn't on the GP58 list.	\$12.00
E432A	Pelvic exam with speculum, no Pap	\$5.00
G590A	Flu shot	\$8.80
G593A	COVID-19 vaccine	\$13.00
G538A	Other vaccine Use the vaccine's own code if it has one: G847A Tdap, G846A Pneumococcal, G843A HPV, G842A Hep B.	\$8.80
G372A	Other injection (B12, Depo, etc.) G373A (\$7.90) if it was the only reason for the visit.	\$4.55
G373A	Injection (B12, Depo, etc.) Only reason for the visit: G373A for the first injection, G372A (\$4.55) for each one after (J54). Injections don't take G700A.	\$7.90
E089A	Female or gender-diverse patient Adds 20% to the physical. Gender identity in the chart.	+20%
Q150A	Explained the FIT and sent the requisition Average-risk patient aged 50–74, at an office visit: checked eligibility, confirmed date of birth and address, taught how to use the kit, sent the requisition. Once per 730 days by any doctor.	\$7.00
Q152A	Reviewed a FIT result and told the patient Once per 2 years. FHG/CCM: only if your roster is under 650 (450 for a new graduate). Not for FHO.	\$5.00
P005A	Did the pregnancy risk review Psychosocial, genetic and medical. Once per pregnancy.	\$55.70
Q040A	Yearly diabetes checks all done (3+ K030A this year) Once a year, after at least 3 K030A in the 12 months (A53). Goes on its own or with any visit. A1C, lipids, ACR, BP, weight, eye referral, foot exam, vaccines offered.	\$65.70
Q015A	Baby is enrolled and under 1 FHO newborn fee: only with A007A on the same date, before the first birthday. Up to 8 per baby.	\$13.99
K023A	Consultation ran 70+ minutes K023A time starts at minute 50: 1 unit at 70 min. At 96+ min bill K023A ×2 (A1).	\$85.25

E082A	You're the most responsible physician for this admission Adds 30% to your admission assessment. Once per admission; not for day surgery, a delivery, a well newborn or a transfer within the hospital (GP42).	+30%
E083A	You're the most responsible physician, acute care hospital Adds 30% to this subsequent or palliative visit. Not for a designated palliative bed in long-term care (GP47).	+30%
E084A	MRP visit on a Saturday, Sunday or holiday Adds 45% instead of E083A. One of E083A/E084A per patient per day (GP47).	+45%
A007A	Also assessed a different problem History and exam. Only for a clearly different diagnosis from the session (GP55).	\$44.55
A003A	Also did a full check for a different problem Full history and exam of every system. Only for a clearly different diagnosis (GP55).	\$95.60
K005A	Also gave 20+ min of mental health care for a different problem 1 unit (20–45 min). Only when its diagnosis is clearly different from this visit's (GP55). Longer? Pick Mental health and add the assessment there.	\$80.00
K007A	Also gave 20+ min of psychotherapy for a different problem 1 unit (20–45 min). Only when its diagnosis is clearly different from this visit's (GP55). Longer? Pick Mental health and add the assessment there.	\$80.00
Q590A	Flu shot was the only reason for the visit Bill with G590A, enrolled or not. Not with an assessment and not with G700A. Appendix Q lists \$8.80; the FHO agreement and OMA guide list \$5.10.	\$8.80
Q593A	COVID vaccine was the only reason for the visit Bill with G593A. Not with an assessment and not with G700A. Appendix Q \$8.80; FHO agreement \$5.60.	\$8.80
Q050A	Heart failure patient: all yearly care elements now documented Once a year, enrolled patient. Flow sheet shows a full physical exam; Na, K, creatinine and eGFR; education on risk factors and self-management; and first-line and symptom medications reviewed.	\$125.00
Q042A	Patient is enrolled and committed to quit Add to the K039A follow-up. Up to 2 a year, within 12 months after your E079A. Appendix Q \$7.70; OMA guide and FHO agreement \$7.50.	\$7.70
Q200A	Enrolled the patient with you today Roster code, billed at \$0. Service date must be the date on the signed enrolment and consent form.	
Q023A	New patient with no family doctor who was in hospital in the last 3 months Acute-care in-patient stay in the 3 months before enrolment (or a newborn of a mother with no family doctor who was in a Level II+ NICU). Enrolment form and Unattached Patient Declaration both signed; same service date as Q200A, which you also bill.	\$150.00
Q053A	New patient Health Care Connect flagged as complex or vulnerable Enrolled within 3 months of registering with Health Care Connect. Once per patient. Pays \$350 today; the \$500 version in the 2026 FHO agreement has no billing code yet.	\$350.00
Q043A	New patient referred by ColonCancerCheck for an abnormal FIT or higher colorectal risk No family doctor before. Enrolment form and New Patient Declaration signed, same service date. OHIP pays \$150 under 65, \$170 at 65–74, \$230 at 75+; you can bill \$150 and OHIP adjusts it.	\$150.00
Q020A	Patient has bipolar disorder \$0 tracking code on every visit claim for this patient. 5+ such enrolled patients earns \$1,200 a year, 10+ earns \$2,400 (2026 FHO agreement).	
Q021A	Patient has schizophrenia \$0 tracking code on every visit claim for this patient, toward the same yearly payment. Appendix Q lists it for FHG too (AQ11); the older OMA guide had FHG use diagnostic code 295 instead.	
Q130A	Flu shot given elsewhere this season (65+) Flu tracking code.	
Q132A	Child's immunizations done elsewhere Childhood immunization tracking code.	
Q011A	Pap done elsewhere Cervical screening tracking code.	
Q131A	Mammogram done Mammography tracking code.	

Q133A	Bowel screening done (FIT or colonoscopy) Colorectal screening tracking code.	
Q140A	Exclude from Pap target Hysterectomy, being followed for cervical disease, or not sexually active.	
Q141A	Exclude from mammogram target Mastectomy, or being treated for breast disease.	
Q142A	Exclude from bowel screening target Known bowel cancer or IBD, colonoscopy in the last 10 years, or on colonoscopy surveillance.	
G700A	The shot or procedure was the only reason for the visit Only for procedures marked (+) in the Schedule: vaccines, the Pap specimen, joint injection, ear syringing, the Epley manoeuvre (J3). Not when you also bill an assessment. FHO: bill Q590A instead for a flu-shot-only visit.	\$8.80

Did a procedure, test or form?

G378A + E542A	IUD insertion	\$60.15
G552A + E542A	IUD removal	\$36.45
G370A + E542A	Joint or bursa injection	\$32.90
G384A	Trigger point injection	\$8.85
Z117A	Freezing warts or skin lesions	\$12.75
Z119A	Freezing 5+ actinic keratoses	\$31.80
Z116A + E542A	Skin biopsy with stitches	\$45.10
Z113A	Skin biopsy, no stitches	\$32.45
Z101A + E542A	Draining an abscess	\$40.85
Z114A + E542A	Removing a foreign body	\$40.30
Z125A + E542A	Cyst or lipoma removal, body	\$47.70
Z122A + E542A	Cyst or lipoma removal, face or neck	\$54.85
Z176A + E542A	Stitches, cut up to 5 cm	\$34.55
Z154A + E542A	Stitches up to 5 cm, face or in layers	\$52.00
Z175A + E542A	Stitches, cut 5–10 cm	\$52.00
Z128A + E542A	Ingrown nail removal	\$48.95
G420A	Ear syringing (wax causing hearing loss)	\$13.15
G403A	Epley manoeuvre for vertigo	\$21.70
G310A + G313A	ECG with your interpretation	\$12.25
J301	Spirometry	\$18.70
Z314A	Nosebleed cautery	\$11.50
Z545A + E542A	Thrombosed haemorrhoid	\$37.90
G202A	Allergy shot (hyposensitisation) Up to 2 with an assessment. Allergy shot the only reason for the visit? G212A (\$12.85) (J4).	\$7.15
G010A	Urine dip, no microscopy	\$2.64
G009A	Urinalysis with microscopy	\$4.90
G014A	Rapid strep test	\$6.80
G002A	Blood glucose in the office	\$2.26
G031A	INR (prothrombin time) in the office	\$6.40
G005A	Pregnancy test Only when an immediate answer is needed to prevent harm to the patient (J67).	\$3.88

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