

Paediatrics OHIP Billing Cheat Sheet 2026

OHIP specialty 26 · Well baby or child check · Developmental or behavioural care · Newborn or delivery · Updated October 2026

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

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

Office consultation

A265A	Consultation Written referral from a physician or NP; written report back (GP16).	\$190.35
A260A	Long consultation, 75+ min All of A265A plus 75+ minutes face to face. Start and stop times in the chart or it pays \$0 (A168).	\$342.25
A662A	Extended consultation, 90+ min All of A265A plus 90+ minutes face to face. Start and stop times in the chart (A168).	\$442.40
A667A	Neurodevelopmental consultation, 90+ min Complex neurodevelopmental condition (autism, global delay). 90+ min with child and caregiver. ADHD alone pays a lesser fee (A168–A169). Limit: 1 per patient per 12 months.	\$456.80
A266A	Repeat consultation Same problem, new written referral, after another doctor cared for the child in between (GP19).	\$104.70
A665A	Prenatal consultation Fetus over 20 weeks at risk; asked by the obstetrician, family doctor or NP. You can still bill a consult on the baby after birth (A170).	\$105.50

- Spent 75 minutes? A260A pays \$342.25, 80% more than A265A (\$190.35). At 90 minutes A662A pays \$442.40. Write start and stop times or it pays \$0 (A168).
- Time for A260A, A662A and A667A counts only face-to-face time, not chart review, and not time spent on other billable procedures (A169).
- OHIP adds the age premium to consults on the remittance: +30% under 30 days, +25% to 1 year, +20% to 2, +15% to 5, +10% to 16 (GP64).
- One consult per patient per diagnosis every 2 years; a second for the same problem pays as an assessment (GP17). Use A263A for a later full work-up.
- Patients 18+ only when you saw them in the year before they turned 18, they have a chronic condition, and they're under 22; or with MOH prior approval (A168).

Office follow-up

A263A	Full specialist assessment Full history of the problem and detailed exam of the affected systems (GP23). Limit: 1 per 12 months (2 if a new, unrelated diagnosis).	\$95.75
A661A	Complex re-assessment Complex, obscure or serious problem. Send a written report to the family doctor or it pays a lesser fee (GP24). Limit: 4 per 12 months, A263A included.	\$86.35
A264A	Re-assessment Full relevant history and exam of one or more systems (GP23). Limit: 2 per 12 months.	\$70.75
A262A	History and exam of the problem Level 2: history and exam enough to make a diagnosis (GP27).	\$50.20
A261A	Quick look or advice Level 1: brief history and exam of one area, or brief advice (GP27).	\$24.85

- Chronic diagnosis on the GP26 list (asthma 493, diabetes 250, autism 299, behaviour disorder 313, specific developmental delay 315, prematurity 765, epilepsy 345)? Tick E078A: +50% on A262A, A263A, A264A or A661A in the office or clinic (GP25). ADHD (314) and global developmental delay or intellectual disability (319) aren't on the list: E078A with either is rejected.
- A661A pays \$86.35 vs A264A \$70.75 when the case is complex and you write to the family doctor. Up to 4 a year (GP24).
- A263A pays almost double A262A. Use it for the full work-up once a year; A264A or A661A after that.
- Phone or video follow-up: A261A–A264A can be billed by phone or video with K301A / K300A (Appendix J). Video pays 100%, phone 85%.
- You asked another specialist for advice about the child, 10+ min by phone (K730A, \$37.05) or by e-consult (K738A, \$16.45)? Both are paid on top of today's visit (A42, A48).

Well baby or child check

A262A	Well baby visit (under 2) Full exam, weight and measurements, advice to parents (GP27, GP34).	\$50.20
A268A	Enhanced 18-month visit Age 17–24 months: well baby care plus an 18-month developmental screen (Rourke) and a parent questionnaire such as NDDS, concerns charted (GP34).	\$74.25
K267A	Check-up, age 2 to 11 No acute illness. History, exam, screening and advice for age (GP21). Limit: 1 per 12 months; extra ones are uninsured.	\$48.05
K269A	Check-up, age 12 to 17 No acute illness (GP21). Limit: 1 per 12 months; extra ones are uninsured.	\$89.15

- Bill each vaccine with its own code from the procedure list (G841A, G846A, G845A and others). They're paid on top of the visit (J3).
- A268A pays \$74.25 vs \$50.20 for a regular well baby visit. Chart the screen result and the questionnaire concerns or it's paid as A262A (GP34).
- K269A for a teen pays \$89.15, almost double K267A. Both are once a year per patient (GP21).
- Child under 6 at developmental risk you follow? Once you've done the screening tool 3 times in 12 months, add K119A (\$142.50) (A170).

Developmental or behavioural care

K122A	Developmental or behavioural care, child ADHD, autism, anxiety, behaviour. You must meet the A172 criteria (35% of billings, or extra training).	\$102.35
K123A	Same, with the family in the room Family developmental or behavioural care (A172).	\$116.15
K005A	Mental health care (no A172 criteria) Use this if you don't qualify for K122A (A172 commentary).	\$80.00
K008A	Interview or counselling with child and/or parent Psychological problem or learning disability. Booked separately; billed on the child's number (A28).	\$80.00
K002A	Interview with relatives or substitute decision-maker About the child's care, not only for consent. Booked, 20+ min (A28).	\$80.00

- Count face-to-face time in one stretch: 20 min = 1 unit, 46 = 2, 76 = 3, 106 = 4. Under 20 minutes it's an assessment (GP55).
- If you qualify, K122A pays \$102.35 per unit vs \$80 for K005A; K123A with family pays \$116.15 (A172).
- Same day as a consult or assessment only for a clearly different diagnosis (GP55).
- Counselling only (K013A) pays \$80 for the first 3 units a year, then K033A \$56.30 (GP58); no other visit that day.
- K122A and K123A can be billed by video or phone with K300A / K301A (Appendix J).

Newborn or delivery

H261A	Routine newborn care Well baby, first 10 days, in hospital or home. 1 per baby (2 if moved to another hospital) (GP32–GP33).	\$82.90
H267A	Called to attend a delivery Constant attendance at the delivery of an at-risk baby; includes the newborn exam (A174).	\$63.45
C263A	Sick newborn assessment Medical specific assessment of a sick newborn in hospital (A173).	\$95.75

- H261A pays \$82.90 vs \$71.15 for the family doctor's H001A.
- An extra trip outside your usual rounds only to discharge the newborn earns a special visit premium (GP33). Otherwise leave 'Called in' at No.
- At a delivery, H267A isn't paid if you bill another service then, except C263A for a sick baby (A174).

NICU day

G600A	Level A, first day Ventilated: full life support, monitoring, parenteral nutrition (J33).	\$376.05
G601A	Level A, day 2 onward Per day.	\$187.95
G610A	Level B, first day Intensive care with monitoring, oxygen and IV therapy, no ventilation (J33).	\$258.05
G611A	Level B, day 2 onward Per day.	\$129.00
G620A	Level C, first day Intermediate: oxygen, non-invasive monitoring or gavage feeds (J33).	\$162.95
G621A	Level C, day 2 onward Per day.	\$81.50

- The day fee includes your consult and all assessments, lines, catheters, intubation, blood gases and ventilation. Don't bill them separately (J33).
- Sole newborn in a low-volume unit: G603A (\$564.00) instead of G600A, up to 25 a year. Under 750 g or 26 weeks: G604A (\$536.95) (J33).
- Moved up or down a level? Second-day fees apply (J33).
- Taking over as MRP after NICU transfer: C142A and C143A (\$71.80 each), but not if you gave the NICU care (GP46).

Hospital in-patient consult

C265A	Consultation Written request on the hospital chart; report back (GP16).	\$190.35
C260A	Long consultation, 75+ min Same rules as A260A. Start and stop times (A173).	\$342.25
C662A	Extended consultation, 90+ min Same rules as A662A (A173).	\$442.40
C667A	Neurodevelopmental consultation, 90+ min Same rules as A667A (A173).	\$456.80
C263A	Full specialist assessment Detailed exam of affected systems; also used as an admission assessment (GP40).	\$95.75
C264A	Re-assessment Admitted within 90 days of your last visit for the same illness (GP40).	\$70.75

- You admitted the child and are MRP? E082A adds 30% to the admission consult or assessment, once per admission (GP42).
- Urgent call from outside the hospital? Use 'Called to the ED' or bill the A-code with premiums; C-codes take no special visit premiums (A173).
- C661A complex re-assessment pays \$86.35 and C266A repeat consult \$104.70 (A173).
- Child in a chronic care or convalescent hospital, or a designated chronic or convalescent bed? Bill the W codes at the same fees: W265A, W260A (75+ min), W662A (90+ min), W667A neurodevelopmental, W565A limited, W266A repeat (A174).

Hospital rounds

C262A	Daily visit Paediatric subsequent visit, 1 a day for the whole stay (GP43).	\$40.05
C122A	MRP, day after admission Once per admission. Second day: C123A, same fee (GP44).	\$71.80
C123A	MRP, second day after admission Once per admission (GP44).	\$71.80
C124A	MRP, discharge day Discharge summary within 48 h; stay over 48 h; not for well newborns (GP45).	\$71.80
C126A	MRP, complex discharge Stay 7+ days, 3+ diagnoses, 45+ min on discharge (A13).	\$95.10
C268A	Concurrent care You direct care, another doctor is MRP. 4 the first week, then 2 a week (GP48).	\$40.05
C142A	MRP, 1st visit after NICU or PICU transfer Child was getting critical, ventilatory, comprehensive or neonatal intensive care there, not just monitoring. Instead of C122A; not if you gave that care (GP46).	\$71.80
C143A	MRP, 2nd visit after NICU or PICU transfer Instead of C123A; same conditions as C142A (GP46).	\$71.80

- As MRP, C122A and C123A pay \$71.80 vs \$40.05 for C262A. Always bill them on days 1 and 2 after admission (GP44).
- E083A adds 30% to every MRP visit; E084A adds 45% on weekends and holidays. Only one a day (GP47).
- Not for admissions for delivery or well newborn care (GP44, GP45).
- After a NICU or PICU transfer to you as MRP: C142A / C143A in place of C122A / C123A (GP46).

Called to the ED

A265A	Consultation Requested by the ED doctor; report back (GP16).	\$190.35
A260A	Long consultation, 75+ min 75+ min face to face, start and stop times (A168).	\$342.25
A263A	Full specialist assessment Your own patient, or no consult request (GP23).	\$95.75
A264A	Re-assessment Full relevant history and exam (GP23).	\$70.75
A262A	History and exam of the problem Level 2 paediatric assessment (GP27).	\$50.20

- Called in from outside the hospital? Set 'Called in' and 'I travelled there': travel + first-patient premiums can add \$58 to \$140 (GP70).
- Already in the hospital, not on ED duty? Still A-codes; the first-person premium applies in the evening, weekend or night even without travel (GP66).
- Admitting the child as MRP? Your ED consult is the admission assessment: tick E082A (+30%) (GP41–GP42).
- Called urgently to a ward patient who isn't yours? Same A-codes, with the in-patient (C9xx) premiums of Table III (GP43, GP72).

Case conference or doctor's call

K704A	Out-patient case conference Pre-booked, MRP is a paediatrician or psychiatrist, 2+ others (school, CMHO agency, therapists). Patient under 18 (A34). Limit: 4 per 12 months, 8 units a day.	\$37.05
K121A	In-patient case conference Pre-booked, MRP plus 2+ others (A33). Limit: 4 per 12 months, 8 units a day.	\$37.05
K731A	Phone advice to another doctor or NP 10+ min. Not to arrange a visit or transfer (A42–A43).	\$47.75
K739A	e-Consult answered Secure electronic request; answer within 30 days (A48).	\$20.50

- Case conference units are 10 minutes: 10 min = 1, 16 = 2, 26 = 3, 36 = 4 (A31). Chart start/stop times, who attended and the decision (A32).
- No phone consult or other case conference for that patient the same day as K704A (A34).
- K731A or K739A pay \$0 if you see the patient that day or the next (A43, A49).

Also bill, if it's true

K001A	Detention: extra time past the consult (per 15 min) After 120 min for A260A, 180 min for A662A/A667A, 60 min for A265A. Paid case by case with a written explanation (GP30–GP31).	\$21.10
K119A	Yearly developmental surveillance (PDAI) Under 6, at developmental risk, you manage them. Screening tool done 3 times and 3+ visits by you in the past 12 months. 1 per 12 months, 6 per lifetime (A170–A171).	\$142.50
K045A	Yearly diabetes management 4+ visits with you in 12 months, you see 100+ diabetes patients a year, flow sheet kept. 1 per 12 months (A99).	\$80.25
E078A	Chronic disease on the GP26 list +50%. Office or clinic only, diagnosis established and coded (GP25–GP26).	+50%
E080A	First visit within 14 days of a hospital discharge Only if you're the child's primary care doctor. Not after a well newborn stay unless NICU (GP28).	\$25.90
K730A	Phoned another doctor for advice, 10+ min You keep caring for the child. Paid on top of your visit. Not to arrange a referral, transfer or test, or mainly to discuss results; not paid if the consultant sees the child that day or the next. 1 per patient per day (A42–A43).	\$37.05
K738A	Sent an e-consult for advice Secure server, answer within 30 days. Paid on top of your visit. 1 per patient per day, 6 per 12 months (A48–A49).	\$16.45
K035A	Reported a medical condition to the MTO Mandatory report under the Highway Traffic Act (licensed teen driver). More than 1 per 12 months for the same patient: manual review (A59).	\$36.25
K034A	Phoned a listed reportable disease to the MOH You made the immediate phone report yourself, e.g. measles, invasive meningococcal disease, invasive Hib, acute bacterial meningitis. 1 per disease per 12 months (A60).	\$36.00
K070A	Filled in a home care referral form You're the doctor giving the child ongoing care and completed it yourself. Paid on top of the visit. Once per Ontario Health atHome admission; not if already receiving home care (A58–A59).	\$34.75
K036A	Northern Health Travel Grant form Paid to both the referring doctor and the specialist (A60).	\$10.25
H267A	Also attended the delivery Called to the delivery of an at-risk baby. With a sick newborn, C263A is the one service paid on top of H267A (A174).	\$63.45
C263A	Baby was sick: also assessed The only service paid on top of H267A at a delivery (A174).	\$95.75
E082A	I admitted the patient and I'm the MRP +30% on the admission consult or assessment. Once per admission; not for well newborns or transfers within the hospital (GP42).	+30%
E083A	I'm the MRP, weekday +30% on MRP visits (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% in place of E083A (GP47).	+45%
C101A	Patient is in the ICU or CCU Not with critical care, ventilatory or NICU team fees (GP103).	\$9.10

Did a procedure or shot?

G841A	DTaP-IPV-Hib (2, 4, 6, 18 months)	\$8.80
G846A	Pneumococcal conjugate	\$8.80
G462A	Rotavirus (oral)	\$8.80
G845A	MMR	\$8.80
G848A	Varicella	\$8.80
G844A	Meningococcal C	\$8.80
G840A	DTaP-IPV (4 to 6 years)	\$8.80
G842A	Hepatitis B	\$8.80
G843A	HPV	\$8.80
G849A	RSV	\$8.80
G590A	Flu shot	\$8.80
G593A	COVID-19 vaccine	\$13.00
G538A	Other vaccine Only when there's no specific code.	\$8.80
G372A	Other injection with a visit IM, SC or intradermal; each injection (J54).	\$4.55
G373A	Injection was the only reason for the visit First injection; each more is G372A (J54).	\$7.90
G700A	Shot or blood draw was the only reason for the visit Once per visit for (+) procedures such as vaccines and venipuncture; not in hospital, not with a consult or assessment that day (J3, J54).	\$8.80
G480A	Blood draw, infant 29 days to under 2 years (GP2).	\$9.90
G482A	Blood draw, child Age 2 to 15 (GP2).	\$7.35
G489A	Blood draw, adolescent Age 16 or 17 (GP2).	\$3.54
G376A	IV start, newborn or infant	\$10.20
Z804A	Lumbar puncture Includes any injection and image guidance (J83).	\$150.00
G282A	Umbilical vein catheter Included in NICU day fees (J33).	\$43.60
G309A	Umbilical artery catheter Included in NICU day fees (J33).	\$45.55
G395A	Resuscitation, first 15 min G391A for each further 15 min (J28).	\$64.70
G211A	Intubation for resuscitation Included in NICU day fees (J33).	\$38.35
G275A	Exchange transfusion	\$205.45
Z111A	Tongue-tie release, no general anaesthetic	\$20.00
G310A + G313A	ECG with your interpretation	\$12.25
J301	Spirometry Not with flow-volume loop J304 the same day (H4).	\$18.70
G420A	Ear syringing or curetting	\$13.15
G014A	Rapid strep test in your office Result, your reading and the treatment decision in the chart (J65, J68).	\$6.80

G010A	Urine dipstick in your office, no microscopy Result, reading and treatment decision in the chart (J65, J68).	\$2.64
G009A	Urinalysis with microscopy in your office Instead of G010A when you also do the microscopy (J68).	\$4.90

Can I bill these together?

Code	With	Together ?	Why
A260A	A265A, A662A, A667A	No	A260A already includes all of A265A; bill the one that matches the time spent (A168).
A662A	A265A, A667A	No	A662A already includes all of A265A; bill one consultation (A168).
A667A	A265A	No	A667A already includes all of A265A (A168).
E078A	A265A, A260A, A662A, A667A, A266A, A665A, A261A, C263A, C264A, C661A, K122A, K123A	No	E078A only adds to A262A, A263A, A264A, A661A or a partial assessment, in the office or clinic, not in hospital (GP25).
E078A	A262A, A263A, A264A, A661A	Sometimes	Only for an established chronic diagnosis from the GP26 list, coded on the claim, in the office or out-patient clinic (GP25–GP26).
E080A	K122A, K123A, K002A, K003A	No	E080A only adds to the services listed in GP28 rule 5 (A261A–A264A, K004A–K008A, K013A, K033A and others); K122A, K123A and the K002A/K003A interviews aren't on it (GP28).
E080A	A265A, A260A, A662A, A667A, A266A, A665A, K267A, K269A, A268A	No	E080A only adds to the services listed in GP28 (A261A–A264A, K005A, K008A and others), not to consultations or check-ups.
E080A	A261A, A262A, A263A, A264A, K005A, K008A	Sometimes	Only for the child's primary care doctor, in the office or home, within 2 weeks of an acute in-patient discharge; K005A and K008A are on the GP28 list too (GP28).
A268A	A262A	No	A268A already includes the well baby visit (GP34).
K122A,K123A,K005A	A262A, A263A, A264A, A661A, A265A, A260A	Sometimes	Mental health or developmental time the same day as a consult or assessment is paid only for clearly different diagnoses (GP55, A172).
K008A,K002A	A262A, A263A, A264A, A265A	Sometimes	Only as a separately booked 20+ minute interview, not the history for the visit (A28, GP61).
H267A	C263A	Yes	When the newborn is sick, C263A is paid on top of attendance at delivery (A174).
H267A	G395A, G211A, C265A, H261A, G282A, G309A	No	H267A isn't paid when you bill another service at the delivery; only C263A for a sick newborn can go with it (A174).
G600A,G601A,G603A,G604A,G610A,G611A,G620A,G621A	G282A, G309A, G211A, G376A, C262A, C263A, C265A, C264A	No	The NICU day fee includes the consult, all assessments, lines, catheters and intubation (J33).
G600A,G601A,G603A,G604A,G610A,G611A,G620A,G621A	C101A	No	C101A isn't paid with NICU team fees (GP103).
G603A	G600A, G604A	No	G603A and G604A are paid in place of G600A, not with it (J33).
C122A,C123A,C142A,C143A	C124A, C126A	No	C122A, C123A, C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP44, GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP44).
C123A	C143A	No	Only one of C123A or C143A per admission (GP44).
C124A	C126A	No	One discharge-day MRP visit per admission (GP45, A13).
C262A	C122A, C123A, C124A, C126A, C142A, C143A	No	One subsequent visit a day; the MRP code replaces C262A on that day (GP43–GP45).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C268A, C265A, C263A	No	E083A/E084A only add to subsequent and MRP visits, not concurrent care or consults (GP47).

Code	With	Together ?	Why
K731A,K739A	A265A, A263A, A264A, A262A, A261A, K122A, K123A	No	Phone or e-consult pays \$0 if you see the patient the same or next day (A43, A49).
K704A	K731A, K730A, K121A	No	No other case conference or phone consult for the patient the same day as K704A (A34).
K730A,K738A	A265A, A260A, A662A, A667A, A266A, A665A, A263A, A264A, A661A, A262A, A261A, A268A, K267A, K269A, K122A, K123A, K005A, K008A	Yes	The referring doctor's phone or e-consult is paid in addition to visits the same day (A42, A48). 10+ min for K730A; not to arrange a referral, transfer or test (A43, A49).
K035A,K034A,K070A,K036A	A265A, A260A, A662A, A667A, A266A, A263A, A264A, A661A, A262A, A261A	Yes	Forms and reports are paid on top of the visit; K070A "in addition to the assessment fee" (A58–A60).
J301,J304	A265A, A260A, A266A, A263A, A264A, A661A, A262A, A261A	Yes	Pulmonary function tests have no same-day rule against a consultation or assessment (H3–H6); bill both. J301 isn't paid with J304 the same day (H4).
J301	J304	No	J301 isn't paid the same day as J304 (H4).
G700A	A265A, A260A, A266A, A263A, A264A, A661A, A262A, A261A, A268A, K267A, K269A	No	G700A is not paid when a consultation or assessment is paid to you the same day (J3).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (page in brackets). Totals leave out the paediatric age premiums on consultations (+10% to +30% under 16, GP64), which OHIP adds on the remittance, and percentage premiums on per-unit services are shown per unit. Special visit premiums follow GP65–GP78. Phone pays 85% of the in-person fee; consultations are video only (Appendix J). Check the Schedule for anything not shown.

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