

Introduction to OHIP Billing

April 2026

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Disclaimer:

Every effort has been made to ensure that the contents of this document is accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable. Regulations with the Government of Ontario including but not limited to the Ministry of Health and Long Term Care (MOHLTC) and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing = by contacting their regional OHIP office.

[OHIP Schedule of Benefits April 1, 2026](#)

For more information email: info@oma.org

OHIP Billing Number

An OHIP billing number is required to submit claims for services rendered. It is also required to register for Medical Claims Electronic Data Transfer (MCEDT) and Health Card Validation (HCV) services.

Eligibility Requirements

To apply for OHIP, applicants must:

- Hold a valid certification from CPSO
- Have an Ontario practice address (list all addresses where services are regularly provided and identify the primary practice site, where possible)
- Complete and sign the [Application for OHIP Billing Number for Health Professionals](#) form
- Provide banking information to support direct payment

Processing Timeline: Applications may take up to 15 business days to process.

Billing Before Receiving an OHIP Billing number

- Claims can be submitted retroactively for up to three (3) months after the billing number is issued.
- Services cannot be billed if provided before the effective date on the CPSO certificate.



Physicians are legally responsible for all OHIP claims submitted and paid in conjunction with their billing number, even if they didn't submit or receive the payment directly.

As such, physicians should always be aware of the claims and payments made under their billing number.

Schedule of Benefits

What is considered insured?

- Listed in the Schedule of Benefits
- Medically Necessary
- Not otherwise excluded by legislation or regulation and
- Rendered personally by a physician (or otherwise delegated where delegation is authorized)

Documentation Required

- All insured services must be documented in the patient's medical record. The record must establish:
 - An insured service was provided
 - The service claimed to OHIP was the service that was rendered; and
 - The service was medically necessary

Definitions (see all definitions in GP2)

Time Definitions

- 12-month period: any period of 12 consecutive months
- Calendar year: the period from January 1 to December 31
- Fiscal year: from April 1 of one year to March 31 of the following year
- Month: a calendar month
- Week: any period of 7 consecutive days
- Day: a calendar day

Age Definitions

- Adolescent: a person 16 or 17 years of age
- Adult: a person 18 years of age and older
- Child: a person 2 years to and including 15 years of age
- Infant: a person from 29 days up to, and less than, 2 years of age
- Newborn: a person from birth up to, and including, 28 days of age

Not eligible for payment

- The service remains an insured service for which the amount payable is \$0.

Only Eligible for payment

- When certain conditions are met and if those conditions are not met, the service becomes not eligible for payment



Patients cannot be charged for services described as “not eligible for payment” or “only eligible for payment” as they remain insured services.

May Include

- Services that are performed in conjunction with the listed service are optional, but when rendered are included in the amount payable for the listed service

With or Without

- Services that are performed in conjunction with the listed service are optional, but when rendered are insured and are included in the amount payable for the listed service

Maximums, Minimums, & Time or Unit-based Services

If a physician does not satisfy the requirements, the service is insured but the amount is \$0.

Minimum

- Less than the number of services required to satisfy the minimum are rendered, the services are not eligible for payment.

Maximum

- X # of services, per patient, per day
- X # of services, per patient, per [specific time period]
- X # of services, with reference to a specific part of the anatomy, per patient, per day



Services in excess of these limits are not eligible for payment.

Time/Unit based services

- The physician must record on the patient's permanent medical record or chart the time when the insured service started and ended.



For minimum required duration of time and number of "units" of service rendered, physicians must document when the insured service started and stopped in the patient's medical records.

Specific Elements of Assessments and Consultations (see definitions in GP40)

Assessments

- A direct physical encounter with the patient.
- Other inquiry (including taking a patient history) carried out to arrive at an opinion as to the nature of the patient's condition.
- Making arrangements for follow-up care.

Consultations

All consultative services require a written referral from a physician or nurse practitioner and a written report back to the referring professional (including findings, opinions and recommendations).

Prefix Meanings

A	Used when submitting claims for consultations and assessments described as the "General Listings"
C	Used for services rendered to Acute Care Hospital- non-emergency in-patient services (excluding emergency department.)
W	Used for services rendered for patients in long term care institutions- non-emergency in-patient services
H	Used for services rendered by a physician on duty in the emergency room.

Special Visit Premiums

A special visit is a visit that requires the physician to assess a patient:

- in response to a request initiated by the patient or a person caring for the patient (non-elective visit); or
- on a physician-initiated visit to a patient's home (elective visit) provided the patient's home is not a Long-Term Care facility, including a nursing home or home for the aged.



Assessments are eligible when:

- Assessment rendered in patient's home (elective or non-elective service)
- Assessment rendered in any other location (non-elective only)

Comprises of: Travel premium and First person or additional person seen

Claims for an assessment rendered in conjunction with a special visit premium are to be submitted using the appropriate A-prefix assessment fee from the "General Listings" (with some exception, such as K023 Palliative care support), regardless of the location or type of facility to which the special visit applies.

- If the assessment is a C005, submit as A005 + SVP
- If the assessment is K023 or G521, submit as is + SVP

Not eligible for payment when:

- For patients seen during rounds at a hospital or long-term care institution (including a nursing home or home for the aged).
- In conjunction with admission assessments of patients who have been admitted to hospital on an elective basis.
- For non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C989).
- For services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients.
- For a visit for which critical care team fees are payable under the Schedule.
- In conjunction with any sleep study service listed in the sleep studies section of this Schedule.
- For services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours, even if held at night or on weekends or holidays.
- For visits in the emergency room where the "H" prefix assessment codes may be payable.
- SVPs are not eligible for payment for elective visits⁵ (unless it is an elective call to a patient's home). There is no SVP for additional patients seen at home visits, regardless of the number of patients seen during a visit to a private home or a multiple resident dwelling (such as an apartment building, retirement home or seniors' complex). The physician must still satisfy the requirement to travel from one location to another in order to be eligible for the first person seen premium.
- SVPs are not eligible for payment to emergency physicians during the time the physician has a scheduled shift to work in the emergency department.
- SVPs are not eligible for payment with A007 or A001 when rendered in a patient's home.

Virtual Care

Establishing physician-patient relationship

- A patient has had at least one insured service with a direct physical encounter with the physician in the preceding 24 months; or
- A patient is enrolled to a physician or another physician in the same group or
- A specialist provides an eligible insured consultation by video; or
- A physician provides any of the following services:
 - A920: Medical management of early pregnancy – initial service (video or by phone)
 - A945: Special palliative care consultation (video)
 - C945: Special palliative care consultation (video)
 - A680: Initial assessment – substance abuse (video)
 - C680: Initial assessment – substance abuse (video)
 - A813/A815: Midwife-requested assessments (video)
 - A802: Extended midwife-requested genetic assessment (video)
 - A801: Comprehensive midwife-requested genetic assessment (video)
 - A800: Midwife-requested genetic assessment (video)
 - A253: Optometrist-requested assessment (video)
 - A256: Special optometrist-requested assessment (video)
 - A957 – Addiction medicine FPA by Video,
 - K680 – Substance abuse – extended assessment by Video.

Comprehensive Virtual Care

If there is a physician-patient relationship:

- 100 % of the OHIP Schedule rate for services rendered by video.
- 85 % of the OHIP Schedule rate for services rendered by phone.
- 95 % of the OHIP Schedule rate for K007 GP psychotherapy, K005 primary mental health care, K197 individual outpatient psychotherapy, and K198 outpatient psychiatric care when rendered over the phone.

Limited Virtual Care

If there is no physician-patient relationship:

- A101: Limited virtual care service – \$20 (video)
- A102: Limited virtual care service – \$15 (phone)



For video consultations to be eligible for OHIP payment, physicians must use a platform included on Ontario's Health Verified Virtual Visit Solution list.

Miscellaneous

Multiple services in a single encounter



Generally, OHIP pays for one assessment per patient interaction. Physicians may bill the appropriate procedural code(s), in addition to the assessment, unless otherwise specified.

Multidisciplinary Care

- It applies to assessments/visits to hospital inpatients.
- When the complexity of the medical condition requires the services of several physicians in different disciplines, each physician visit constitutes a subsequent visit.
- It requires manual submission of claim for the second physician.

Transfer of Care

- When Physician A acts as a substitute for Physician B.
- For example: where the first physician is leaving temporarily on holidays and is unable to continue to treat the patient.
- Referrals for consultations should not be issued to Physician A. Use the appropriate subsequent fee code.

Consultation with Another Physician

Title	Code	Amount	When to use
Telephone Consultation (Physician to Physician) - All services rendered by the consultant physician to provide opinion/ advice/recommendations on patient care, treatment and management to the referring physician. The consultant physician is required to review all relevant data provided by the referring physician or nurse practitioner. - Minimum of 10 minutes of patient-related discussions. - Both referring and consultant physicians must be in Ontario at the time of service. - This service is <u>eligible for payment in addition to visits or other services provided</u> to the same patient on the <u>same day</u> by the same referring physician.			
Consultant Physician	K731	\$47.75	Not on duty Limit: 1 payment per patient per day
Referring Physician	K730	\$37.05	Not on duty Limit: 1 payment per patient per day
Physician on duty in an emergency department or hospital urgent care clinic			
Consultant Physician	K735	\$47.75	Limit: 1 payment per patient per day
Referring Physician	K734	\$37.05	Limit: 1 payment per patient per day
Email Consultation (Physician to Physician) - This service is <i>only eligible for payment</i> if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request. - Both the request and opinion are sent by electronic means through a <u>secure server</u>. - The consultant physician shall provide the report to the nurse practitioner and the patient's primary care provider, if applicable.			
Referring physician	K738	\$16.45	Eligible for payment when the call is to collect additional data to support specialist re-assessment.
Consultant physician	K739	\$20.50	

Not eligible when:

- Discussion is to arrange the transfer of patient care.
- In whole or part to arrange for a consultation, assessment, or K-prefix time service, procedures or diagnostic investigations.
- To discuss the results of diagnostic investigations.
- When specialists renders a visit on the same day/following day the physician-to-physician consultation for the same patient.

OHIP Claim Reconciliation Process

Submission Timeline

Submit Claims	3 months to submit
Error Report	Unlimited amount of time to correct
Remittance Advice Inquiry (RAI)	7 months to submit RAIs from the date of the RA
Internal Review Committee	20 days of receiving response from RAI

Understanding Error and Explanatory Codes

Error Codes: 3-character codes found in the error report.

Explanatory Codes: 2-character codes found in the RA report.

Billings on your Error report won't show up on your RA report. Cross reference to find gaps.

Processes

Resubmission of a previously rejected claim that is now stale dated

Correct all errors and resubmit the claim(s) in a single stale dated claim file via the Medical Claims Electronic Data Transfer (MCEDT).

- Send an email to ClaimsManagement@ontario.ca with
 - Billing number /group number
 - List of outstanding claims
 - Confirmation of stale-dated claims was uploaded
 - Error reports

Note: Billings on your Error report won't show up on your RA report.

Manual Review

Inquiries regarding services that are unusual, complex, or don't fit the standard billing rules. For example, billing the same code on the same day for the same patient or resubmitting an incorrect version code.

- Use the manual review indicator field in your EMR
- Send supporting documentation through eSubmit

Remittance Advice Inquiry (RAI)

Inquiries regarding overpayments, underpayments or claim submissions that were modified by the Ministry of Health. For example, change a partial assessment to a general assessment.

- Inquiries can be submitted electronically to the ministry using [eSubmit](#) or mailed/faxed to 1-905-434-4186 using a "[Remittance Advice Inquiry](#)" form (0918-84).

Non-OHIP Billing

Uninsured Services

- Services provided by physicians that are not publicly funded under OHIP.
- Physicians can charge patients for uninsured services, but must abide by [CPSO's Uninsured Services Billing and Block Fee Policy](#).
- It is professional misconduct to charge a fee that is excessive in relation to the services performed.
- Examples include copy of medical records, missed appointments, optional cosmetic procedures, disability tax credit, retirement home forms and travel cancellation forms.
- Common forms that a physician cannot charge for its completion include: application for accessible parking permit, accessible transit eligibility application forms, children's aid society forms (on behalf of a child), Canadian passport application, ministry of health forms (e.g. assistive devices etc.)*
- Some exceptions apply when a specific code is listed in the OHIP schedule of benefits, such as home care application or LTC application form.

Third Party Billing

- Receiving payment from an external payer – an entity other than MOH or the patient, such as WSI, insurance company, lawyer, government agency.
- Examples include: completion of medical reports, disability forms or independent medical exams.
- Resource: [WSIB](#), [OMA resources on efficiency on forms](#)



Tips:

- It is important to understand which services are uninsured.
- Adhere to CPSO's policy by communicating fees clearly in advance, obtaining patient consent where required, and maintaining transparent documentation and receipts for all charges.

Family Medicine

Terminology

Shadow Billing	Physicians under certain funding models, are required to submit “shadow bills” for certain OHIP service codes to the Ministry of Health, but with dollar amounts set to zero, <i>not</i> for direct payment but to track service data for funding adjustments and metrics.
Capitation Payments	An annual fee to provide a specific list of services to enrolled patients. The amount paid per patient varies by gender and age.
Acuity Modifier	Adjust compensation rates (capitation) based on patient’s age, gender and complexity.
In basket	Routine codes provided to enrolled patients.
Out of basket	Are for more specific ailments that are not covered in capitation payments and thus paid as a FFS.

Income Stabilization (IS): FHO and FHN

- Supports physicians joining a FHO/FHN while building their patient roster before transitioning to blended capitation.
- Provides guaranteed income for up to 12 months, provided monthly cumulative enrolment targets are met.
- Designed to offset the financial costs of starting a new practice while you build your roster.
- Monthly targets are cumulative — plan for vacation, illness or patient de-rostering.
- Participation signals an expectation that the physician will remain in the group and provide comprehensive care to their enrolled patients.
- Once participation ends, physicians transition to the FHO as a signatory member and are paid under the FHO Agreement.
- Early exit is permitted if the annual enrolment target is reached before 12 months, with at least 30 days’ written notice to the Ministry.
- FTE ratio changes also require 30 days’ written notice.
- All changes take effect on the first day of the month (e.g., notice given Feb. 15 → effective April 1).
- Eligibility criteria and enrolment targets must be maintained to remain in the program.



GP Practice Designation

- The GP Focused Practice Designation recognizes specialized services provided by GP Focused Practice physicians
- Focus areas included, but are not limited to, sleep, addictions, geriatric medicine, sports medicine, complex wound care, obstetrics & gynecology, vasectomy, pain management, allergy, dermatology, infectious disease and orthopedics.
- Applications are due February 1st and September 1st of each year.

Best Practice Billing Tips



1. Know the rules before you bill

- Use the most current Schedule of Benefits from the Ontario Health Insurance Plan (OHIP).
- Understand service limits, time requirements, and premium eligibility.
- Clarify whether you are billing fee-for-service or under a FHO/FHN model.

2. Document to support the claim

- Your chart must justify the service code billed (history, exam, medical decision-making).
- Ensure time-based codes clearly document start/stop times when required.
- Record location, modality (e.g., in-person vs. virtual), and patient consent where applicable.

3. Bill accurately and promptly

- Submit claims daily or weekly to avoid backlog and missed deadlines.
- Verify patient eligibility at each visit.
- Double-check diagnostic and fee codes before submission.

4. Understand common errors

- Avoid duplicate billing or billing mutually exclusive codes.
- Be aware of frequency limits and age restrictions.
- Ensure virtual care meets Ministry requirements.

5. Monitor and reconcile

- Review remittance advice reports regularly.
- Track rejected or reduced claims and resubmit promptly.
- Audit your own billing periodically to identify patterns or gaps.

6. Stay current

- Watch for updates from the Ministry of Health and the Ontario Medical Association (OMA).
- Attend billing education sessions early in practice.

Tip: Bill what you did, document what you billed, and review what you were paid.

Additional Resources

- [OHIP Schedule of Benefits](#)
- [OHIP Claims Submission Process](#) (including manual review and stale dated claims)
- [OMA Post Payment Review Process](#)
- [OMA Billing Resources including delegated services, special premiums etc.](#)
- [OHIP Info Bulletins](#)
- [Education and Prevention Committee Billing Briefs](#)
- [SGFP Billing Resources](#)
- [OMA Learns](#) (member login required)
- OMA Mobile App (for billing resources)
- [OMA Physician's Uninsured Guide](#)