Understanding Your OHIP Cheque

- Your Out-of-Country claim is reimbursed in Canadian funds only.
- Your claim was processed based on the information you provided.
- Out-of-Country physician claims are reimbursed based on the fees a physician would receive for the same service if provided in Ontario, or the amount actually billed, whichever is less.*
- Out-of-Country hospital claims for in-patient care are paid at established rates (up to $400 [Canadian] per day for higher level hospital care, e.g. intensive care unit; up to $200 [Canadian] per day for any other kind of hospital care).*
- Out-of-Country hospital claims for out-patient care are paid at the established rate of up to $50 [Canadian] per day.*

*OHIP will pay only for insured, emergency out-of-country health services that are rendered to an insured person.

Anyone may request a review of their out-of-country claim simply by making the request in writing. The request may either be mailed, or faxed to the ministry at:

**OHIP Eligibility Review Committee**
Ministry of Health and Long-Term Care
Health Services Branch
1055 Princess Street, P.O. Box 168
Kingston ON K7L 5V1
Fax: 613-548-6557

- Please keep your cheque stub as it may be required by your supplemental insurance company.
- For further information:
  - Please contact the ministry INFOline at 1-800-664-8988 (toll-free in Ontario only); TTY 1-800-387-5559 (hours of operation are 8:30 A.M. to 5:00 P.M.) to access your nearest OHIP claims office.
Explanation of Codes
30 – This service is not a benefit of OHIP.
32 – Our records show that this service has already been submitted and paid.
50 – Paid according to the Schedule of Benefits for Physician Services.
65 – This service is included in the approved hospital daily rate.
AP – This payment is made according to the legislated rate for the service rendered.
DL – Allowed at listed fee for laboratory tests performed in the physician’s office.
D7 – Not allowed in addition to the other procedure claimed.
D8 – This service can only be paid when billed with another specific procedure.
G1 – Other critical/comprehensive care already paid.
S3 – Second surgical procedure allowed at 85% of fee listed in the Schedule of Benefits for Physician Services.
S7 – Normal pre and post-operative care included in fee paid for surgery these visits are not payable.
M1 – The maximum fee/number of services payable has been reached for this service.

For the full list of explanatory codes, please go to:

Schedule of Benefits:
http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

Health Insurance Act:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h06_e.htm

OHIP Out of Country Services: