

**Health Claim**

Provider Number

Ministry use

Confidential when completed

Health Number	Version	Date of Birth year month day	Account Number	Payment Prog.	Payee	Service Location Indicator
Referring Provider Number	Master Number	Inpatient Admission year month day				

Service code	Fee Submitted	No. of Services	Service Date yyyy mm dd	Diagnostic Code	Service code	Fee Submitted	No. of Services	Service Date yyyy mm dd	Diagnostic Code

fold here

**For Ministry Use Only**

<input type="checkbox"/> Health Number is missing/invalid <input type="checkbox"/> Invalid Version Code <input type="checkbox"/> Date of Birth missing/incorrect <input type="checkbox"/> Date of Birth/ Health Number mismatch <input type="checkbox"/> Health Number not registered with Ministry of Health and Long-Term Care <input type="checkbox"/> Payment Program is missing/invalid <input type="checkbox"/> Payee is missing/incorrect <input type="checkbox"/> OHIP # required for this service date (submit using OHIP Claim Card) <input type="checkbox"/> Health Number required for this service date <input type="checkbox"/> Please resubmit as Reciprocal Claim	<b>Missing/Incorrect Service</b>
<input type="checkbox"/> Referring Provider No. <input type="checkbox"/> Master Number <input type="checkbox"/> Admission Date <input type="checkbox"/> Service Code <input type="checkbox"/> Service Location Indicator	<input type="checkbox"/> Fee <input type="checkbox"/> Number of Services <input type="checkbox"/> Service Date <input type="checkbox"/> Diagnostic Code <input type="checkbox"/> Missing/Incorrect information as highlighted on claim card
Date	Station

Please detach here and return the top portion to the ministry. The bottom portion is a copy for your records.



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Provider's Copy