



From Training to Practice: Your Guide to Getting Started with OHIP Billing

2026 Edition



Introduction



Starting your medical career is an exciting milestone, filled with opportunities to build patient relationships, develop your clinical expertise, and establish the practice you've worked so hard to achieve. However, many physicians quickly discover that the administrative side of running a medical practice, including understanding medical billing, can be just as important as delivering quality patient care.

Whether you're a medical student preparing for the next steps, a new graduate beginning independent work, or a physician new to Ontario, navigating OHIP billing, payment models and choosing your pathway can present a significant learning curve, and many physicians find themselves learning the business side of medicine while simultaneously focusing on patient care and practice growth.

This guide was developed to help simplify OHIP billing and provide a practical foundation for success. Throughout this resource, you'll find key information on selecting a payment model, getting started with billing, and practical insights designed to help you bill with confidence, avoid common pitfalls, and better understand Ontario's healthcare system.

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CHAPTER

01

Choosing Your Pathway

Options for Starting Your Practice

One of the first career decisions new primary care physicians face is choosing where and how to practice. The right path depends on your professional goals, geographic location, desired lifestyle, and the type of patient population you hope to serve. While there are many opportunities available across Ontario, most new physicians begin their careers in one or more of the following settings.

OHIP-Funded Clinics

Many new primary care physicians begin practicing in community-based clinics funded through OHIP payment models such as **FHO**, **FHG**, **CCM**, or fee-for-service (**FFS**).

These clinics provide an opportunity to build a patient roster, develop continuity of care, and gain experience managing a broad range of clinical settings. Depending on the clinic and payment model, physicians may also benefit from mentorship, administrative support, and access to established patient populations.

Hospitals

Hospital-based practice offers exposure to acute care medicine and can include opportunities in emergency departments, hospitalist programs, inpatient care, and specialty services.

For new physicians, hospitals can provide valuable clinical experience, collaborative multidisciplinary environments, and opportunities to develop expertise in managing complex patients. Compensation structures may vary depending on the role and funding arrangement.

Locum Tenens

Locum tenens positions allow physicians to provide temporary coverage for physicians away on vacation, parental leave, illness, or other commitments.

Locum work can be a valuable option for new graduates who want to explore different practice settings before committing to a permanent position. It provides exposure to various payment models, clinic workflows, patient populations, and geographic locations while offering flexibility and valuable experience.

There is no single "right" way to start practicing. Many physicians combine clinic work, hospital shifts, and locum opportunities throughout the early stages of their careers. Understanding the advantages and challenges of each setting can help you make informed decisions as you transition from training into independent practice.



Understanding Ontario's Healthcare Payment Models

One of the first decisions you'll make as a physician is selecting a practice model. Your payment model influences how you are compensated, how you bill, and the incentives and responsibilities associated with your practice.

While every model is designed to support patient care, they differ significantly in how revenue is generated and how physicians are paid.

Model	How Physicians Get Paid	Benefits	Considerations
Fee-for-Service (FFS)	Physicians bill OHIP for each insured service provided, with compensation based on services rendered.	Straightforward billing structure, flexibility, and full control over your practice.	Income can fluctuate based on patient volume and there are fewer enrolment-based incentives available and lower income predictability.
Family Health Group (FHG)	Physicians bill fee-for-service while accessing enrolment benefits, premiums, and incentives.	Maintains the familiarity of Fee-for-Service while providing additional earning opportunities through bonuses and premiums.	Requires patient enrolment and participation in after-hours coverage, with medium income predictability in a group physician setting.

Model	How Physicians Get Paid	Benefits	Considerations
Family Health Organization (FHO+)	Compensation includes capitation, premiums, incentives, and patient attachment incentives.	Greater revenue stability, compensation for time, patient attachment incentives, and support for comprehensive patient care.	Includes after-hours coverage requirements, patient roster management, and performance measures such as Continuity of Care.
Comprehensive Care Model (CCM)	Physicians bill fee-for-service and receive enrolment-based premiums and incentives for rostered patients.	Allows physicians to maintain an independent practice while benefiting from patient enrolment incentives.	Requires patient enrolment and participation in after-hours coverage, with medium income predictability in a solo physician setting.
Emergency Department Alternate Funding Arrangements (AFA)	Compensation is funded through hospital and Ministry agreements and includes shadow billing and incentives.	More predictable compensation in high-volume emergency department settings.	Payment structures vary by site and shadow billing requirements may apply.

Although the billing process may appear similar across Ontario, each payment model compensates physicians differently. Some models rely heavily on fee-for-service billings, while others combine billings with capitation payments, premiums, bonuses, incentives, or alternative funding arrangements.

As a result, understanding your payment model is very important and will influence your workflows, billing, and how you approach practice management throughout your career.

Income Stabilization for FHO Physicians

For new graduates and physicians starting a primary care practice in Ontario, Income Stabilization can provide valuable financial certainty during the first year of practice before joining a FHO. The program offers guaranteed compensation for up to 12 consecutive months while physicians build their patient roster and work toward monthly enrolment targets.

Understanding how the program works before joining a FHO can help you plan your transition, set realistic enrolment goals, and build a strong foundation for long-term practice success.

Eligibility Criteria

To be eligible:

- Physicians **must** establish a **new** practice, not transfer a roster from an existing physician.
- Physicians must meet Ministry enrolment requirements by actively working toward **monthly patient roster growth targets** throughout the stabilization period. Physicians may exit the program before completing 12 months if they meet their roster targets early.
- Additionally, if you are currently participating in any patient enrolment models, including FHO, FHG, or CCM, or if you maintain a patient roster, you will **not** qualify.
- Please note that participation in the Income Stabilization Program is limited to **one instance only**.

How Do I Get Started?

To participate in the Income Stabilization Program, physicians must first join a FHO and meet the Ministry's eligibility requirements.

Once enrolled, physicians are required to meet monthly patient enrolment targets and submit claims through their FHO group according to program billing requirements. Monthly enrolment targets are cumulative, so the Ministry recommends that you proactively enroll more than the target amount to account for vacation, illness, or patients who are de-rostering.



Read more about
Income Stabilization
in [our blog](#).



CHAPTER

02

Getting Started with Billing

Why Every Physician Needs to Understand Billing

Medical billing is more than submitting claims; it directly impacts physician compensation, practice performance, and financial sustainability. Even small billing errors, missed premiums, or incorrect code selection can result in lost revenue, rejected claims, and unnecessary administrative work. Yet many physicians enter practice with limited formal billing education.

Whether you practice in a **fee-for-service**, **blended**, **capitation**, or **alternative funding model**, understanding how billing works can help you reduce claim rejections, capture eligible premiums and incentives, and make more informed practice decisions.

The goal of this guide is not to turn physicians into billing experts. Rather, it is to provide the knowledge needed to understand the fundamentals of OHIP billing, recognize common opportunities and pitfalls, and confidently navigate the Ontario healthcare system throughout every stage of practice.

Before You Start Billing

Before submitting your first OHIP claim, there are a few important administrative steps that need to be completed. Ensuring these requirements are in place before you begin practicing can help prevent payment delays and administrative issues later on.

Getting Started Checklist:

✓ Register with the CPSO

Obtain your licence to practice medicine in Ontario.

✓ Apply for an OHIP Billing Number

This number is required to submit claims and receive payment for insured services.

✓ Complete Ministry of Health Registration

Ensure all required physician registration forms have been submitted and approved.

✓ Set Up Direct Deposit & Practice Information

Provide the Ministry with your banking information, practice address, and contact details to ensure accurate payment processing.

Missing or incomplete registration information can delay claim submissions and payments. Taking the time to confirm these details before you begin practicing will help create a smoother transition into independent practice.

How Submitting Claims Works

Once you have your OHIP billing number and Ministry registration in place, the next step is understanding how claims are submitted and how payments are processed.

Set Up MCEDT and OBP BPS Access

Before you can begin submitting OHIP claims, you must first register for both **MCEDT** (Medical Claims Electronic Data Transfer) and **OBP BPS** (Ontario Business Portal Business Partner Site, formerly Go Secure). Without these systems in place, you will **not** be able to submit claims, receive payments, access your Remittance Advice (RAs), or review claim rejections.

Registering for MCEDT ensures your **Electronic Medical Record (EMR)** system can communicate properly with the Ministry of Health's claims system, allowing electronic claim submission and the receipt of submission and rejection files.

OBP BPS provides access to important **billing and payment** information, including Remittance Advice (RA), error files and payment records, as well as Remittance Advice Inquiries (RAI).

While most physicians submit claims directly through their EMR, MCEDT can also be used to manually submit claims if your EMR is unavailable or experiencing technical issues.



Know the OHIP Submission Cut-Off Dates

The OHIP claims submission cut-off is typically the **18th of each month**. If the 18th falls on a weekend or statutory holiday, the deadline is moved to the next business day. Staying within these timelines is important to ensure claims are processed within the current payment cycle and to avoid unnecessary payment delays.

Understanding how claims are submitted and where to access your billing information is an important part of managing your practice. Even if you work with a billing company or clinic administrator, knowing how to access your claims, payments, and Remittance Advice can help you identify issues early and stay informed about your billing performance.



Check out our
**OHIP Billing
Cut-Off Dates
[Calendar](#)**



Understanding the Schedule of Benefits

The Schedule of Benefits (SOB) is the Ministry of Health's official fee guide that outlines the services insured under OHIP and the fees payable for those services. *Whether you're billing assessments, consultations, procedures, or premiums, the Schedule of Benefits is the primary resource physicians use to determine not only the appropriate codes to bill for each service, but also how services are properly defined.*

The Schedule of Benefits is divided into sections based on specialty and service type. Within each section, you'll find:

- ✓ **Fee Codes** – The billable service code (e.g., A001, A007)
- ✓ **Fee Values** – The amount payable for each insured service
- ✓ **Service Descriptions** – Details outlining what is included in the service
- ✓ **Payment Rules & Restrictions** – Information regarding frequency limits, eligibility requirements, and billing restrictions
- ✓ **Explanatory Notes** – Additional guidance that helps physicians determine when a service is eligible for payment

Here is an example of how the layout of a fee code looks, with the value and payment rules:

A007	Intermediate assessment or well baby care	44.55
E432	when pelvic exam including speculum is performed outside of hospital or ICHSC, to A001 and A007 add	5.00
A002	Enhanced 18 month well baby visit (see General Preamble GP34)	73.95
Payment rules:		
1. Special visit premiums listed in Table VI on page GP75 of this Schedule are not eligible for payment with A007 or A001 when rendered in a patient's home.		

The Schedule of Benefits also contains detailed definitions and billing requirements for consultations, assessments, procedures, premiums, and many other services. These definitions and rules can often be found in the General Preamble 2 (GP2) of the SOB.

Billing Options for New Doctors

Once you begin practicing, you'll face decisions about how your billing will be managed. While there are several approaches available, each comes with its own advantages and considerations.

Option 1: Do-It-Yourself Billing

Some physicians choose to manage their own billing and submit claims directly through their EMR or billing software.

While this approach provides complete control over the billing process, it also requires time, ongoing education, and a strong understanding of OHIP billing rules. New physicians are often balancing patient care, administrative responsibilities, and practice development, making it difficult to stay current with changing billing requirements and payment rules.

Common challenges include:

- Missed premiums and incentives
- Claim rejections and resubmissions
- Time spent reviewing Remittance Advices
- Keeping up with Ministry updates and billing changes

At DoctorCare, we find physicians who manage their own billing often miss significant revenue opportunities. On average, our billing assessments identify **\$25,000–\$30,000** in recoverable revenue annually from billing errors alone, with additional revenue often left unclaimed through missed premiums, bonuses, and incentive programs.

Option 2: Internal Billing Staff

Some clinics employ dedicated billing staff to submit and manage claims on behalf of physicians.

This can reduce the physician's administrative workload, but success often depends on the individual biller's experience and expertise. Internal staff may support multiple physicians and responsibilities within the clinic, which can limit the time available for proactive billing review, optimization, and rejection management.

Common challenges include:

- Variability in billing knowledge and experience
- Limited visibility into billing performance
- Staff turnover and training requirements
- Difficulty keeping pace with changing billing rules

Option 3: Full-Service Billing Support

A full-service billing provider manages the billing process on behalf of the physician, including claim submission, rejection follow-up, payment reconciliation, reporting, and ongoing billing support.

For many new physicians, this option provides access to dedicated billing expertise while reducing administrative burden. Experienced billing teams monitor Ministry updates, identify billing opportunities, manage claim issues, and help ensure physicians are appropriately compensated for the services they provide



Key advantages are:

- Identifying, correcting, and resubmitting rejected or unpaid claims to help reduce lost revenue.
- Ensuring eligible premiums, incentives, and bonus payments are properly captured and submitted.
- Ongoing claim monitoring and billing reviews, helping identify missed opportunities and support accurate physician compensation.
- Regular reporting, providing visibility into billing activity, payment trends, claim performance, and overall revenue.
- Spending less time managing billing issues and claim follow-up, focusing more on clinical practice.

For many physicians, full-service billing support provides peace of mind, improves financial performance, and frees up valuable time to focus on delivering quality patient care.

How DoctorCare Can Help

Navigating Ontario's billing system can be challenging for new physicians. From understanding fee codes and payment models to tracking premiums and managing claim rejections, billing requires time and expertise.

DoctorCare's [Billing Care](#) service helps simplify the process by:

- Managing claim submission, correction, and resubmission
- Identifying eligible premiums, incentives, and bonus opportunities
- Providing billing guidance and ongoing support
- Delivering reporting and financial insights
- Reducing administrative workload so physicians can focus on patient care

Whether you're a resident, a new graduate, or a physician new to Ontario, our team can help you build confidence in your billing and maximize your revenue potential.

CHAPTER

03

Building Your Roster

How to Roster Patients

Patient enrolment (rostering) is a key component of many primary care models and helps establish an ongoing physician-patient relationship.

Before a patient can be added to your roster, they must agree to formally enrol with your practice. This process begins by having the patient review and sign the appropriate Ministry enrolment form, confirming that they have selected you as their primary care provider.

Once the enrolment form has been completed, the physician can submit the applicable rostering code to OHIP to officially attach the patient to their practice. The enrolment is then processed by the Ministry and reflected in the physician's roster records.

Common Patient Enrolment Codes

Q200 – Standard Patient Enrolment

Q200 is used to enrol most patients in your practice and add them to your roster (including patients in residential or nursing homes).

Q202 – Long-Term Care (LTC) Patient Enrolment (FHO)

Q202 is used when enrolling patients who reside in long-term care settings. Care may be provided across multiple locations, including long-term care homes (or LTC with hospital beds).

Selecting the appropriate enrolment code ensures patients are correctly attached and supports accurate compensation, reporting, and continuity of care tracking.

Roster Management Best Practices

If you choose a capitation-based model like the FHO+ model, your patient roster is one of the most important assets of your practice. Beyond supporting continuity of care, an accurate and well-maintained roster helps ensure appropriate compensation, supports patient attachment initiatives, and reduces administrative burden.

Review Your Roster Regularly

Periodically review your enrolled patient list from the Ministry (RCP file) to ensure your EMR remains accurate and up to date. Many physicians find there are discrepancies between the RCP file sent by the Ministry and what is reflected in their EMRs, which is why it's important to review the report and update it accordingly.

Reconcile Patient Changes

Monitor roster additions, removals, transfers, and deceased patients to help maintain accurate records; these are also found in your RCP report.

Monitor Outside Care

Understanding where and how your patients access care outside your practice can help identify trends that may impact continuity of care and patient engagement. A well-managed roster supports continuity of care, improves reporting accuracy, and ensures your patient population is accurately reflected in Ministry records.



Tips for Enhancing Patient Care

Building a successful practice involves more than managing billings and rosters. Creating strong patient relationships and supporting access to care can improve both patient outcomes and practice performance.

Best Practices for Patient Engagement

Understand Patient Utilization Patterns

Monitoring patient behaviour, including outside use, can help identify opportunities to strengthen continuity of care and patient engagement.

Improve Access to Care

Providing access to appointments and ensuring patients are aware of after-hours and weekend coverage options within your group or care circle can help keep care within the practice.

Connect Patients to Available Resources

Supporting patients through additional services can improve care outcomes. Depending on your practice setting, this may include:

- Family Health Team (FHT) resources
- Community support programs
- Chronic disease management services
- Allied health professionals and specialist referrals

Patients who understand how to access care and available support services are more likely to remain engaged with their primary care provider, helping improve continuity of care and the overall patient experience.

CHAPTER

04

The OHIP Billing Basics

Common Codes Every New Family Physician Should Know

With thousands of codes available in the Schedule of Benefits, knowing where to start can feel overwhelming. While every practice is different, there are several core OHIP codes that new family physicians will use regularly and should become familiar with early in their careers.

Core Assessment Codes

A001 – Minor Assessment

Typically used for straightforward, brief patient encounters involving advice or information and assessment.

A007 – Intermediate Assessment

One of the most billed family medicine codes. Used when a patient requires a more detailed assessment than a minor visit.

A003 – General Assessment

A comprehensive assessment involving a complete history, physical examination, and appropriate documentation.

A005 – Consultation

A consultation occurs when a physician or nurse practitioner formally refers a patient to another physician for an expert opinion due to the complexity, seriousness, or uncertainty of the patient's condition.



Download our
[Assessment vs.
Consultation guide](#)

Virtual Care Codes

Comprehensive Virtual Care (+ K300 / K301)

Many in-person assessment codes can be provided virtually and may be eligible for comprehensive virtual care premiums when all payment requirements are met, most importantly that the patient is rostered or was seen in person in the last 24 months.

Limited Virtual Care (A101 / A102)

This assessment code is used when a virtual encounter does not meet the criteria for a comprehensive virtual assessment (the patient is not rostered or has not been seen in person in the last 24 months).

As virtual care continues to evolve, physicians should ensure they understand the eligibility requirements and documentation standards associated with each type of virtual service.

Preventive Care & Chronic Care Codes

Chronic disease management is a key part of every family physician's practice. Conditions like diabetes, congestive heart failure, smoking cessation and others require continuous monitoring, patient education and support.

Several codes help physicians track preventive care activities and chronic disease management while contributing to incentive and bonus programs.

Q020 & Q021 Primary Care Serious Mental Illness (PCSMI)

Some physicians may come across cases of bipolar disorder and schizophrenia in their clinics, yet many might be unaware of billing codes that monitor these conditions in practice. Q020 and Q021, used in the FHO and FHG models, are billed annually for enrolled bipolar and schizophrenic patients, contributing to the annual special premiums and bonuses categories.



Check out our quick reference guide on [Virtual Care billing](#)

K030 – Diabetic Management Assessment

K030 is a service provided by the most responsible physician (MRP) for continuing the management and support of a diabetic patient, and requires a lab requisition for blood work, as well as the completion of the diabetes flow sheet.

Q040 – Diabetes Management Premium

Managing diabetic patients requires a comprehensive approach, including regular assessments, treatment plans for continuity and quality of care, and proactive patient communication strategies. Q040 recognizes ongoing management of diabetic patients and is an add-on after three K030 diabetic visits have been billed in the last 12 months.

Q050 – Congestive Heart Failure Premium (CCM, FHG and FHO)

Supports the management of eligible patients living with congestive heart failure and can be billed for enrolled patients once per year.

E079 – Initial Discussion for Smoking Cessation

This is an add-on code for the initial discussion with the patient that is only eligible for payment when rendered with one of the following service codes: A001, A003, A004, etc.

K039 – Follow-Up Discussion

K039 is the smoking cessation follow-up visit; this code can only be billed after the initial discussion E079 has occurred.

Q042 – Smoking Cessation Counselling Fee

This fee add-on can be applied to the K039 follow-up visit code, serving as an additional incentive for physicians to provide counselling to rostered patients.

Preventive care and chronic disease management play an important role in improving patient outcomes while also contributing to a physician's overall compensation through premiums, incentives, and bonus programs.

New FHO+ Hourly Billing Codes

For physicians practicing under FHO+, new hourly billing codes have been introduced for care provided to rostered patients:

Code	Procedure	Description	Rate
Q310	Direct Patient Care	In-person visits, video visits, in-office telephone care, etc.	\$80/hour (4 units)
Q311	Direct Telephone Care (Out-of-Office)	Telephone care provided while not physically in the clinic.	\$68/hour (4 units)
Q312	Indirect Patient Care	Patient-specific tasks such as charting, report reviews, etc.	\$80/hour (4 units)
Q313	Clinical Administration	Non-patient-specific clinical work, such as preventive care planning.	\$80/hour (4 units)

While these updates better reflect the full scope of physicians' work, they also introduce new billing codes, limits, and documentation requirements, making time tracking a key part of your workflow.



Learn more about how to bill the new [hourly billing codes on our blog](#).

Workplace Safety and Insurance Board

Unlike most patient encounters that are billed directly through OHIP, **Workplace Safety and Insurance Board (WSIB)** visits follow a slightly different process. This often creates confusion for new physicians because a **WSIB** encounter involves both submitting workplace injury documentation and billing the patient visit itself. Understanding these two separate steps early can help prevent payment delays and reduce administrative burden.

Step 1: Submit WSIB Forms

When treating a patient for a workplace injury or illness, physicians are often required to complete and submit WSIB forms directly to WSIB. The most common forms are the [Health Professional's Report \(Form 8\)](#) and the [Health Professional's Progress Report \(Form 26\)](#). These forms can be submitted digitally or by fax, and payment is made directly by WSIB.

Step 2: Bill the Visit Through OHIP

The patient visit itself is billed through OHIP using the appropriate assessment code (such as A001 or A007), but the insurer must be changed from the default HCP to WCB (WSIB). Once submitted, the claim is processed through OHIP and can be reconciled through your Remittance Advice (RA).

Important WSIB Billing Considerations

- ✓ WSIB form codes and visit codes should not be submitted together on the same claim. For example, an A007 assessment and a WSIB form code must be billed separately.
- ✓ If a patient presents with a work-related injury but no WSIB form has been initiated, the physician may bill the visit as an A001 or A007 using WSIB as the insurer.
- ✓ [Register or create a portal](#) for WSIB reconciliations on WSIB forms.

Strategies to Avoid Common Billing Mistakes

Medical billing mistakes are common, especially early in practice. Fortunately, many can be avoided by developing good billing habits from the start. Here are some strategies you can implement to optimize your billing process:



Submit Claims Daily

Submitting claims regularly helps reduce missed billings, have consistent monthly revenue, and makes it easier to identify issues quickly.

Regularly Review Error Reports

Claims can be rejected for a variety of reasons. Reviewing error and rejection reports weekly helps ensure issues are corrected and resubmitted promptly.

Bill Compatible Codes

Certain OHIP codes cannot be billed together. Understanding payment rules and explanatory notes, and understanding what the error code means, can help prevent unnecessary rejections.

Keep Your Roster Up-to-Date

For physicians in enrolment models, maintaining an accurate patient roster is important for compensation, patient attachment incentives, and reporting.

Understand Continuity of Care

Under FHO+, physicians are expected to maintain a minimum Continuity of Care threshold. Monitoring patient utilization and outside use can help prevent potential impacts on compensation.

Capture Eligible Premiums

Many physicians miss premiums they are entitled to bill, including:

- Q012 – After-hours premium
- Q040 – Diabetes management premium
- Q050 – Congestive heart failure premium
- Q015 – Newborn episodic care (FHO only)
- Q042 – Smoking cessation counselling

Many billing issues stem from administrative oversights rather than clinical errors. Building strong billing habits early can help reduce rejections, improve revenue capture, and increase confidence in managing your practice.



Understanding Your Remittance Advice and Error Reports

Once you've started billing, it's important to understand how to review your payments and identify claims that require follow-up. In this section, we'll cover what information is included on your Remittance Advice (RA), how to interpret common error reports, and what to do when claims are rejected or adjusted.

Your Remittance Advice (RA) is one of the most important billing documents you'll receive as a physician. It provides a summary of your claims, payments, adjustments, and any claims that were rejected or reduced during processing. You would receive this monthly, typically within the first 7 days of every month.

What to Review on Your RA

Payments Received

Your RA outlines the services that were paid for and the amounts deposited into your account.

Adjustments and Deductions

Review any reductions, recoveries, or payment adjustments that may affect your compensation.

Explanatory Codes

Claims that were not paid will appear with an accompanying explanatory code explaining why the claim was rejected or settled.

Understanding Error Reports

Error reports identify claims that require attention before payment can be issued. Reviewing these reports regularly allows you to correct issues and resubmit claims promptly.

Common reasons for errors include:

- Incorrect fee codes
- Invalid diagnostic codes
- Incompatible code combinations
- Missing patient or billing information

When Do You Receive Payment?

OHIP payments are typically deposited monthly following the Ministry's claims processing cycle, typically on the **14th of every month**. Claims submitted before the monthly submission deadline are generally processed and reflected on the next available Remittance Advice.

Many physicians focus on submitting claims but spend little time reviewing their billing results. Understanding your RA and error reports helps ensure claims are paid correctly, reduces lost revenue, and allows you to identify issues before they become recurring problems.



How DoctorCare Can Help

Ministry reports can often be complex, detailed, and time-consuming to interpret. For physicians looking for clearer visibility into their billing performance, [DoctorCare's Practice Care](#) reporting transforms this information into practical, easy-to-understand insights.

Our reports provide actionable data on claim activity, billing opportunities, revenue trends, and key practice metrics, helping physicians identify opportunities, monitor performance, and make more informed decisions about their practice.

MONTHLY REVENUE BREAKDOWN DEC. 2025 - APRIL 2026					
RA Month	Jan. 2026	Feb. 2026	March 2026	April 2026	May 2026
Service Period	Dec. 2025	Jan. 2026	Feb. 2026	March 2026	Apr# 2026
Capitation Payments					
Base Rate Payment ("BRP")	\$29,990.07	\$30,090.40	\$28,144.26	\$30,059.93	\$29,639.51
Comprehensive Care Capitation Payment ("CCCP")	\$6,378.71	\$6,397.46	\$5,982.34	\$6,386.19	--
Total Capitation Payments	\$36,368.78	\$36,487.86	\$34,126.60	\$36,446.12	\$29,639.51
Benefit Management Details					
Total Number of Patients	2,170	2,167	2,158	2,159	2,160
Average Monthly Capitation per Patient	\$16.76	\$16.84	\$15.81	\$16.88	\$13.72
Shadow Billing (Blended Fee-For-Service)	\$977.60	\$839.13	\$1,652.99	\$68.20	\$5.06
Out of Basket Billing (Excluded codes)					
Enrolled patients	\$2,967.40	\$1,814.23	\$2,774.56	\$93.90	\$698.80
Non-enrolled patients	\$513.70	\$333.40	\$161.10	\$25.00	\$256.80
Network Colleague	\$10.37	\$0.77	\$0.77	-	\$52.91
Total Out of Basket	\$3,491.47	\$2,148.40	\$2,936.43	\$118.90	\$1,208.51
Other Fee For Service					
Non-enrolled patients - In-Basket (Included codes)	\$1,107.80	\$612.00	\$1,359.85	\$134.80	-
WVSB	-	-	-	-	-
Total Fee-For-Service	\$1,107.80	\$612.00	\$1,359.85	\$134.80	-
Access Bonus					
Maximum Special Payment (Total Potential)	\$5,556.64	\$5,495.32	\$5,237.73	\$5,522.01	\$5,521.02
Enrolled Patient Outside Use (Total Outside Use)	\$6,311.00	\$3,500.12	\$4,402.04	\$2,953.58	\$1,918.78
Non-UTC Access Bonus Payment	(\$754.36)	\$1,995.20	\$835.69	\$2,568.43	\$3,602.34
UTC Access Bonus Payment	-	-	-	-	-
MSP Acuity Payment	-	-	-	-	-
Net Access Bonus	(\$754.36)	\$1,995.20	\$835.69	\$2,568.43	\$3,602.34
Special Premiums					
Hospital	-	-	-	-	-
Labour and Delivery	-	-	-	-	-
Office Procedures	-	-	-	-	-
Palliative Care	-	-	-	-	-
Home Visits	-	-	-	-	-
Prenatal	-	-	-	-	-
Long Term Care	-	-	-	-	-
PC IMB	-	-	-	\$1,000.00	-
Total Special Premiums	-	-	-	\$1,000.00	-
Preventive Care Bonuses					
Other Payments and Adjustments	(\$35.66)	(\$580.68)	\$162.47	\$12,895.36	\$1,283.36
Total Estimated Monthly Revenue	\$41,909.99	\$39,506.71	\$40,238.14	\$50,663.38	\$42,956.44

Latest Service Date Paid: June 18, 2026

Services Not Covered Under OHIP

Not every service provided in a physician's office is insured by OHIP. Understanding which services are uninsured and how to bill for them is important to ensure you are fairly compensated for your time and expertise.

Common Uninsured Services Include:

- ✓ Prescription renewals completed without a visit
- ✓ Sick notes and medical certificates
- ✓ Driver's medical examinations
- ✓ Tuberculosis (TB) testing for employment or school requirements
- ✓ Insurance forms and third-party paperwork

The [Ontario Medical Association \(OMA\)](#) publishes an annual guide outlining recommended fees for uninsured services, including updates to existing fees and newly added services. Physicians should review this guide regularly and establish a consistent fee schedule within their practice.

Options for Charging Uninsured Services

Once you've identified which services are uninsured, the next step is deciding how your practice will charge for them. There is no one-size-fits-all approach, and many physicians use a combination of methods depending on their patient population, practice structure, and administrative preferences.

Charging Per Service

Many physicians charge patients individually for each uninsured service provided. While straightforward, this approach can create administrative work and often requires staff to follow up on outstanding payments.

Block Fee

An annual block fee allows patients to pay a fixed amount that covers eligible uninsured services throughout the year. This model can improve patient convenience, simplify administration, and help physicians recover the costs of providing uninsured services.

Charging Internally vs. Using a Third Party

Physicians can manage uninsured services programs internally or work with a third-party provider. While in-house management offers greater control, it also requires time and resources for billing, collections, and patient communication.

Third-party solutions can streamline administration, automate processes, and reduce the operational burden on clinic staff, allowing physicians to focus on patient care.

Best Practices for Uninsured Services

Here are some best practices that can help reduce administrative challenges, improve patient communication, and ensure physicians are appropriately compensated for services that fall outside of OHIP coverage:

- ✓ Develop a clear uninsured services policy
- ✓ Communicate fees to patients in advance whenever possible
- ✓ Post fee schedules in the clinic and on your website
- ✓ Ensure staff understand which services are uninsured and how they should be processed

Finding the right balance is important. While many physicians choose to waive fees or offer reduced rates in certain circumstances, uninsured services still require physician time, clinical judgment, and administrative effort. Physicians should feel comfortable charging for these services when appropriate.

Uninsured Services Billing Support from PatientSERV

For new graduates and physicians who are new to practicing in Ontario, managing uninsured services can add administrative complexity to an already busy practice.

As the OMA's preferred partner and now part of WELLSTAR's integrated healthcare solutions ecosystem, **PatientSERV** offers a fully managed solution that helps streamline administration, improve patient convenience, and support revenue recovery.

Key features include:

- ✓ Fully managed uninsured services programs and block fee administration
- ✓ EMR-integrated workflows and payment processing
- ✓ Automated invoicing, receipts, and payment collection
- ✓ Staff training, patient education, and ongoing support
- ✓ Real-time reporting and program insights

PatientSERV has helped generate an additional **\$15,000-\$40,000** in annual revenue for physicians through a structured uninsured services program and reduces the administrative burden of managing uninsured services, allowing physicians and clinic staff to focus on patient care.

Learn more about how they can help with uninsured services in your practice today.

[Learn more about PatientSERV](#)

CHAPTER

05

Setting Yourself Up for Success

Building Good Billing Habits Early

Developing strong billing habits early in your career can help reduce errors, improve revenue capture, and save time in the long run.

Billing Best Practices

✓ Conduct Monthly Billing Reviews

Regularly review rejected or pending claims to identify recurring issues and improve billing accuracy.

✓ Become Familiar with Common Fee Codes

Understanding the codes and payment rules relevant to your practice will help you bill confidently and avoid common mistakes.

✓ Know Your Premiums and Incentives

Many physicians miss eligible premiums simply because they are unaware they exist. Take time to understand the incentives available within your payment model.

✓ Maintain Consistent Billing Workflows

Submit claims regularly—ideally daily—and review encounters at the end of each day to ensure claims are complete and accurate before submission.

Good billing habits are easier to build than they are to correct. Investing time in your billing processes early can help improve efficiency and reduce administrative burden throughout your career.

When to Seek Billing Support

Managing billing independently can work for some physicians, but there are situations where additional support may be beneficial.

You may want to consider billing support if:

- ✓ You have a growing billing backlog
- ✓ Claims are frequently rejected, and you don't have time to correct them
- ✓ Administrative work is taking time away from patient care
- ✓ You suspect you're missing premiums or incentives
- ✓ You're struggling to keep up with billing changes
- ✓ Your current billing process or in-house solution isn't meeting your needs
- ✓ You're unsure where to start with OHIP billing

For many physicians, billing support provides access to expertise, reduces administrative workload, and helps improve billing accuracy and revenue capture. The earlier billing challenges are addressed, the easier they are to resolve.

Seeking support can help prevent small issues from becoming larger administrative or financial problems.

Explore Your Options with DoctorCare

Starting practice comes with a steep learning curve, and medical billing is often one of the most challenging areas for new physicians.

Whether you're a medical student preparing for practice, a new graduate, or a physician new to Ontario, DoctorCare can help simplify the transition.

Book a **free consultation** to learn how **DoctorCare** can support your transition into practice.

We'll walk you through billing basics, common pitfalls, and how to build an efficient, optimized practice from the start.

[Book your consultation](#)

Keeping Up with Ministry Changes

OHIP billing rules, payment models, and Ministry requirements continue to evolve. Staying informed is an important part of maintaining billing accuracy and practice performance.

Sign Up for Updates to Stay Current

OHIP Pulse

A monthly summary of key Ministry bulletins and OHIP updates, delivered in a practical, easy-to-read format.

DoctorCare Newsletter

Stay informed about new billing resources, webinars, guides, and educational content designed for Ontario physicians with our monthly Ontario Newsletter.

Sign up for updates today!

Bonus Resources

Looking to continue your learning? Explore some of DoctorCare's most popular educational resources:

Guide: [Comprehensive OHIP Billing Guide for FHO Physicians](#)

Webinar: [A Guide to Roster Management and Patient Recalls](#)

Webinar: [Starting Your Practice in Ontario: A FHO Primer](#)

Blog: [Commonly Missed Q-Codes Every Physician Should Know](#)

Blog: [Best Practices to Avoid OHIP Audits and Penalties](#)

Blog: [Comparing Ontario's Primary Care Payment Models](#)



Who we are

DoctorCare is the largest provider of billing and practice support for over **4,000** physicians across Canada. On average, we have helped doctors recover **\$25,000-\$30,000** of revenue per year.

Our solutions and services are designed to help doctors optimize their practice, maximize their revenue, and improve patient care.

Our Services

Practice Care

Our flagship product helps primary care physicians optimize the performance of their practice by providing:

- Billing optimization
- Roster management
- Bonus optimization
- Continuity of Care tracking
- FHO group management and more!

Patient Care

Our end-to-end rostering and patient recall solution helps streamline your processes by alleviating the administrative burden of patient management processes:

- Roster management
- Patient recalls (Diabetic patients, etc.)
- Patient communication

Billing Care

Our billing service alleviates the pain of medical billing submission and managing and correcting errors in your EMR:

- Automated claim submission
- Error correction and re-submission
- Monthly billing reports to review our work.

Uninsured Medical Billing Services

We offer a customizable platform to effectively manage uninsured medical service billings, to meet the specific needs of each practice:

- Patient education and communication.
- Patient sign-up and billing fee-for-service and annual plans.
- In-depth financial reporting.

Have questions?

- Email our support team at info@doctorcare.ca
- Find helpful [blogs and case studies here](#).
- Discover our [billing quick reference guides and webinars here](#).
- [Subscribe to our newsletter and OHIP Pulse here](#) to get the latest updates in healthcare.



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