



Comprehensive OHIP Billing Guide for FHG Physicians

2026 Edition



Introduction



Medical billing in Ontario is complex — and for many physicians, it's an area that receives little formal training. As a result, billing errors and missed opportunities can impact your practice's revenue.

For physicians currently practicing in a Family Health Group (FHG) or deciding to practice in a FHG, staying current with OHIP billing rules, fee schedule updates, premiums, and incentive payments is essential to ensuring you're billing accurately and receiving the compensation you're entitled to.

At **DoctorCare**, we help bridge the gap between clinical care and billing clarity.

Explore our **Comprehensive OHIP Billing Guide for FHG Physicians** to simplify your workflow and optimize your claims.

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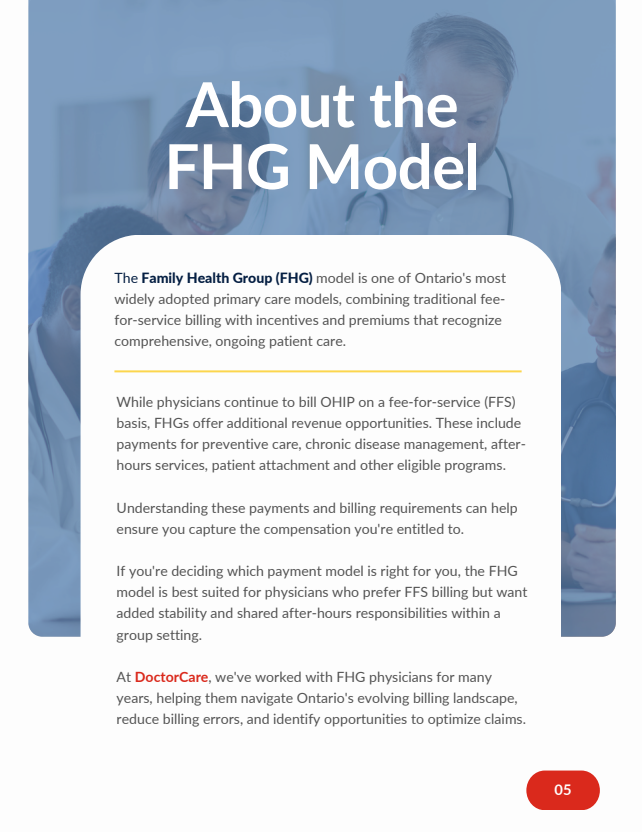
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CHAPTER

01

Getting
Started
with a FHG



About the FHG Model

The **Family Health Group (FHG)** model is one of Ontario's most widely adopted primary care models, combining traditional fee-for-service billing with incentives and premiums that recognize comprehensive, ongoing patient care.

While physicians continue to bill OHIP on a fee-for-service (FFS) basis, FHGs offer additional revenue opportunities. These include payments for preventive care, chronic disease management, after-hours services, patient attachment and other eligible programs.

Understanding these payments and billing requirements can help ensure you capture the compensation you're entitled to.

If you're deciding which payment model is right for you, the FHG model is best suited for physicians who prefer FFS billing but want added stability and shared after-hours responsibilities within a group setting.

At **DoctorCare**, we've worked with FHG physicians for many years, helping them navigate Ontario's evolving billing landscape, reduce billing errors, and identify opportunities to optimize claims.

Ministry Reports You'll Receive From OHIP

Each month, physicians receive detailed report files from the Ministry of Health, providing information on their submitted claims to help **track payments, monitor rejections** and **review bonus status**. However, these reports are often lengthy, complex, and challenging to interpret, making it difficult for physicians to identify potential issues in their billing.

Here are some of the **key reports** that physicians would see come through their EMR:

Remittance Advice (RA) Report

This report lists all the claims you submitted that were approved or paid with adjustments from the previous month's cut-off date.

Claims Error Report (ER)

This report lists all the claims you have submitted that have been rejected or refused. Each claim on this report will have a corresponding three-character reason code.



An OHIP cut-off date refers to the deadline by which all of your billing claims will be accepted and paid at the following payment date.



This cut-off date is typically the 18th of each month unless it coincides with a weekend or holiday.



To stay on top of payment and submission dates, download our [2026 OHIP Billing Calendar](#) [here](#).



Roster and Capitation Payment Reconciliation Report (RCP)

This report contains a summary of all your currently rostered patients, as well as any roster activity happening in the month, such as rostering and de-rostering, start and end dates, and adjustments in capitation.

Target Population/Service Report (TPSR)- Previous/Projected Report

The TPSR Previous Report summarizes the preventive care services completed by your eligible patient population during the previous fiscal year. The TPSR Projected Report identifies patients who are due for preventive care services in the current year, helping you proactively target care and maximize preventive care incentives.



Reports from the Ministry can be difficult to interpret and create much confusion about what is paid and what isn't. Our [Practice Care](#) reports compile all these files monthly and condense them into an easy-to-read summary that provides insights into your scope of practice.



Special Premiums and Bonuses

Special Premiums and Bonuses are an integral part of the FHG compensation model. They make up a chunk of a physician's revenue and create many opportunities to maximize earnings.

FHG Comprehensive Care Premium: The FHG Comprehensive Care Premium is an annual incentive that rewards physicians for providing the following comprehensive primary care services to their enrolled patients: **A001, A003, A007, A008, A888, A900, A902, C010, C882, G365, G548, G590, G840, G841, G842, G843, G844, G845, G846, G847, G848, K005, K013, K017, K022, K023, K030, K130, K131, K132, K133.**

As part of the 2024 PSA, the FHG Comprehensive Care Premium increased to 15% effective April 1, 2026 (rising to 20% on April 1, 2027).

Special Premium Bonuses: Special Premiums are additional payments that physicians receive on top of their regular fee codes for enrolled and/or non-enrolled patients in the following bonus categories:

- Home Visits
- Palliative Care
- Long-Term Care
- Primary Care Serious Mental Illness (PCSMI) (enrolled patients only)



As of 2026, FHG physicians are eligible to receive up to \$22,400 in these bonus categories.



For a complete list of eligible codes, download our [Special Premiums and Bonuses guide here.](#)

Preventive Care: The Preventive Care Bonus is a financial incentive for eligible family doctors enrolled in the CCM, FHG, FHO+, and FHN payment models who provide timely and regular preventive screenings and immunizations for their rostered eligible patients.



For the full update on Preventive Care, [read our blog here](#).

Patient Attachment Bonus: Patient attachment bonuses are additional payments that physicians receive for rostering unattached patients, who are new to their FHG group, which were announced in early 2026.



DoctorCare offers a **free practice assessment** where we provide a comprehensive report highlighting the different bonus structures, valuable recommendations on how to maximize your bonuses, and identifying additional areas of opportunity that may have been previously overlooked.





Patient Attachment Bonus

As part of the evolving healthcare system, patient attachment remains a key priority in expanding access to care across Ontario. To support this, physicians are eligible for attachment bonuses when enrolling unattached patients into their practice.

Established vs. New Graduate Physician

The value of the patient attachment bonus depends on whether you are classified as an established physician or a new graduate.

- **Established physicians** receive a base attachment bonus (**\$100-\$180**) that varies depending on factors such as patient age and practice location (e.g., Rurality Index).
- **New graduate physicians** are eligible for enhanced attachment incentives, typically receiving higher payments per newly enrolled patient (**\$150-\$270**).

Eligibility

To qualify for the patient attachment bonus:

- The patient must be unattached at the time of enrolment
- The patient must be new to your group (not previously rostered within your FHG) and the enrolment must be completed in accordance with Ministry requirements

A patient may qualify if they:

- Do not currently have a family physician
- Have lost access to their previous physician due to relocation, retirement, or other changes
- Have not previously been rostered to a primary care provider

Important exclusions:

- Patients transferred through a batch roster transfer (e.g., taking over a retiring physician's full roster)
- Patients switching from another local physician
- Patients previously rostered within your group and returning

Each patient is eligible for one attachment bonus only.

How to Bill the Patient Attachment Bonus

At present, new attachment bonus fee codes are still being finalized.

In the interim:

- Continue billing the standard enrolment code **Q200**
- Ensure all required enrolment documentation is completed:
 - New Patient Declaration
 - Enrolment and Consent forms

When new codes are released:

- Eligible attachment bonuses will be paid retroactively (effective July 1, 2025, if applicable)
- Claims will need to be submitted using the new fee code(s)
- The service date will be backdated to the first eligible insured service after enrolment



Roster Management Best Practices

The Ministry of Health requires each patient to be enrolled or “rostered” with a family physician. Being rostered helps strengthen the doctor-patient relationship. However, physicians may often encounter discrepancies between the patients they believe are enrolled and those actually rostered to them by the Ministry.

In many cases, the Ministry’s roster count is lower than what’s shown in the EMR. This mismatch can happen for several reasons:

- Patients accidentally rostered with another doctor at a walk-in clinic.
- Q200’s are being rejected or are never being submitted.
- Patients falling off your roster without you knowing.

Identifying and reconciling these discrepancies is critical. It ensures that you're providing optimal patient care and receiving the compensation you're entitled to.



How to Roster Patients

To enroll a patient, submit the **Q200** code.

Patient Attachment Codes

In addition to rostering patients, there are additional attachment incentives available for:

- Health Care Connect upgrade (TBD)
- Mothers and newborns (TBD)
- Multiple births (TBD)

At this time, these new bonus codes are not yet available for billing, with the exception of the existing Health Care Connect Complex code, **Q053**. It's important to note that each patient is only eligible for one attachment bonus.

Maintaining an accurate roster requires regularly reviewing your patient list and comparing it with the Ministry's records to confirm enrolment. Ensuring roster size and composition helps meet your goals. In the FHG model, effective roster management is crucial for quality care, practice efficiency, and compensation.



Eliminate discrepancies between your EMR and the Ministry's records with DoctorCare's [Patient Care](#) service, a comprehensive, end-to-end roster management solution. We identify non-rostered patients, send rostering forms, and bill rostering codes.



CHAPTER

02

FHG Billing Codes Deep Dive

Assessments and Consultations

Assessments and consultations are among the most commonly used billing codes physicians encounter in daily practice.

Assessments

Assessments are encounters where patient history is taken and a physical exam is performed. This service can be provided either virtually or in person, at a place other than in a patient's home.

Assessments include, but are not limited to:

- A001- Minor Assessment
- A003- General Assessment
- A007- Intermediate Assessment
- K131- Periodic Health Visit (age 18 to 64)
- K132- Periodic Health Visit (age 65+)



Assessment	Consultation
Does not require a physician referral	Must have a physician referral

Consultations

Consultations are assessments **requested (in writing)** by a referring physician or nurse practitioner who has professional knowledge of the patient and identifies the consultant physician as competent to give advice.

Consultations include, but are not limited to:

- A005- Consultation
- A006- Repeat Consultation
- A905- Limited Consultation

After-Hours (Q012) Premium

The FHG structure requires groups to offer patients after-hours availability for improved access to care. FHG physicians are expected to participate in After-Hours visits weekly for a **minimum of three hours**. Depending on the size of the FHG, at least one physician must work 5 p.m. - 8 p.m. on Monday to Thursday OR for three hours on the weekends.

The after-hours premium code **Q012** is among the most commonly unoptimized billing opportunities for physicians. Many doctors miss out on additional revenue simply because they're unsure of when this premium applies during their workday.

Q012 is a fee code for enrolled patients seen during regular after-hours services held **before 8 a.m. and after 5 p.m. on weekdays, weekends, or statutory holidays**.

Physicians are eligible for a **30%** premium on the value of the following fee codes (in-person or virtual care) for scheduled and unscheduled services provided during scheduled After-Hours coverage: **A001A, A003A, A004A, A007A, A008A, A888A, E089A, K005A, K013A, K017A, K030A, K033A, K130A, K131A, K132A, K133A, Q050A and Q888A (FHO+ only)**.



The maximum number of services allowed for Q012 is one per patient visit. If more than one is submitted in the same claim, this will result in an error. Q012 must be submitted on the same claim as the qualifying visit.

Procedure Billing

In-office procedures are a routine and essential part of primary care. From preventive screening to minor interventions, these services are often delivered daily within your clinic and play an important role in patient care.

Recent updates under the Physician Services Agreement have increased the value of several commonly performed procedures — in some cases by **up to 50%** — better reflecting the time and resources required to provide these services in a primary care setting.

Ensuring these procedures are consistently identified and billed can help align your compensation with the care you are already providing. Here is a shortlist of a few of the procedures that have seen increases in their fees:

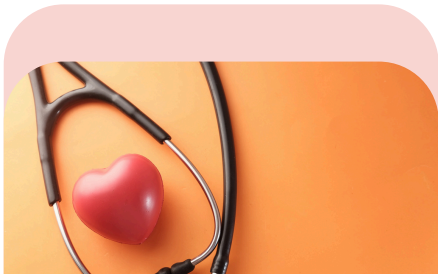
Code	Procedure	Fee Value
G378	IUD insertion	\$47.50
G841-G848	Immunizations	\$8.80
Z101	Skin biopsy (simple)	\$28.20
Z116	Skin lesion excision / biopsy	\$32.45

Chronic Disease Management

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.

In the FHG model, these visits offer valuable billing optimization opportunities through specific codes and premiums that recognize the added time and complexity involved in managing chronic conditions. Yet, many physicians may be unaware of these billing options, resulting in missed claims and unrealized revenue potential.

In this guide, we focus on the three primary categories of Chronic Disease Management: *Diabetes, Heart Failure Management, and Smoking Cessation.*



Diabetes Management

Physicians bill three main fee codes for their diabetic patients: **K030, Q040, and K029.**

K030 - Diabetes Management Assessment

This is a service provided by the most responsible physician (MRP) for continuing the management and support of a diabetic patient. K030 is billable up to **four times** per 365 days. The code requires a lab requisition for blood work, as well as the completion of the diabetes flow sheet which is also available on our website to [download](#).

Q040 -The Diabetes Management Incentive

This service is payable to physicians who provide ongoing management using a planned care approach consistent with Diabetes Canada's guidelines. The Q040 incentive code can be billed upon **completing three K030** assessments in the last 12 months and is billable on an annual basis.



Physicians can earn up to **\$25,000 of additional yearly revenue by following these best practices for Diabetic Management:**

- Schedule the next diabetes management visit right after their current visit.
- Ask your staff to proactively call such patients to schedule a diabetes visit.
- Set up a reminder in your EMR for those overdue for diabetes visits.
- Bill Q040 along with the third K030 in the past 12 months.
- Set up a reminder in your EMR for those who are due for a Q040 claim.

K029 - Insulin Therapy Support

K029 is payable to physicians who provide support and counselling on intensive insulin therapy requiring at least three injections per day using an infusion pump or training on insulin for patients who use glucose meters, insulin pumps or insulin pens.

Similar to K030, the K029 code requires the completion of blood work and a diabetes flow sheet. The fee code is limited to a maximum of **6 per patient per 12-month period**.



Managing your diabetes patients just got easier! Our [Patient Care](#) service identifies patients overdue for follow-up, conducts monthly diabetic recalls, and helps set up a recall process through your online booking system.



K029 cannot be combined with the Q040 incentive code when billed.



The first K030 billed to a patient must be an in-person visit. Otherwise, the claim will come back errored, and the assessment will not count toward the incentive.



[Read our blog here](#) for more tips on Diabetes management.

Congestive Heart Failure Management

The Congestive Heart Failure Management Incentive **Q050** is a fee code premium that can be billed once per year for enrolled patients diagnosed with heart failure.

Prior to submitting **Q050**, at least **two in-person patient visits** billed with the '428- Congestive Heart Failure' diagnostic code in the previous 365 days are required. Billing Q050 also requires completing a flowsheet to be maintained in the patient's records.

With busy schedules, it's easy to overlook billing **Q050**, missing a valuable opportunity that supports proactive patient care. Here are some **best practices** to help you effectively manage both care and billing for your heart failure patients:

- Pick a date in the year when you update your patient's heart failure flow sheet and bill Q050.
- Generate a list of heart failure patients to assist you when billing your Q050.
- Set up a reminder in your EMR for patients who are overdue for Q050 billing.



Download our Congestive Heart Failure [flowsheet here](#).



Smoking Cessation Management

Smoking cessation is another area where physicians have the opportunity to enhance billing through structured patient support. However, many are **unaware** of the available codes, unsure how to bill them, or may simply forget. When managed effectively, smoking cessation management allows physicians to bill three incentive fee codes: **E079, K039, and Q042**.

E079 – Initial Discussion

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, A005, A006, A007, A008, A905, K005, K007, K013, K017, K130, K131, K132, P003, P004, P005, P008, W001, W002, W003, W004, W008, W010, W102, W104, W107, W109 or W121**.

K039 – Smoking Cessation Follow-up

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.



You must document the discussion in the patient's medical record using a flow sheet that aligns with best practices.



K039 is limited to a maximum of two services in the 12-month period, following the E079.



Similar to K039, the Initial Discussion code (E079) has to be billed before the Q042, and the add-on should be billed within the 12-month period following the service date. It's limited to two in the past 12 months.

Mental Health Care

Mental Health Care is an essential part of many physicians' practices, whether through scheduled visits or conversations that arise during general appointments. Without a strong understanding of Mental Health billing, it's easy to miss eligible codes and leave revenue on the table.

Here are the most common mental health codes physicians will encounter:

K005 – Primary Mental Health (Individual Care)

This is the primary code for Mental Health visits for individual care and is payable for visits where physicians provide advice and information regarding diagnosis, treatment, health maintenance, and prevention. It is a **time-based** code that requires a minimum of 20 minutes of direct patient contact (one unit), and start and stop times must be documented. If an A-prefix assessment is billed on the same day, the diagnostic codes must be different, and generic diagnostic codes like 799 are not allowed.

K007 – Psychotherapy

This service is any form of treatment for mental illness, behaviour maladaptions and problems assumed to be of an emotional nature, with the purpose of treating **existing symptoms and/or behaviour patterns**. Like K005, it is a time-based code that requires a minimum of 20 minutes.



A unit means half an hour or a major part of the patient visit.

K013 – Counselling

This is a patient visit dedicated solely to an educational dialogue with a physician. This service is offered to develop awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information.

K623 – Form 1 Application

For a patient to receive a psychiatric assessment, a physician must fill out the Form 1 application. The application for psychiatric assessment in accordance with the Mental Health Act includes necessary history, examination, and notification of the patient, family, and relevant authorities.

By familiarizing themselves with these codes and their associated requirements, healthcare providers can not only optimize their practice's revenue but also enhance the quality of mental health support they provide to patients.



Prenatal and Postnatal Care

Prenatal and postnatal care are essential services that involve a series of visits and assessments aimed at providing consistent and timely care throughout each stage of the pregnancy journey. Having accurate billing knowledge in this area helps ensure the care you provide is properly documented and compensated.

There are three main codes physicians can bill for **prenatal patients**:

P003 – The Prenatal Major Visit

A prenatal general assessment includes a full history, an examination of all parts or systems, and advice to the patient. This can only be billed once **per pregnancy per physician**.

P004 – The Prenatal Minor Visit

This code includes all subsequent visits for pregnant patients. The number of times this can be billed is unlimited.

P005 - The Antenatal Preventative Health Assessment

P005 is completed by the most responsible physician for antenatal risk, examining all current psychosocial, genetic and medical issues affecting antenatal risk. This can be billed once **per pregnancy per patient**.



For more information on Prenatal and Postnatal care, [download our guide here](#).

There are also three main codes physicians can bill for **postnatal visits**:

P008 – Postnatal Care in Office

This should be billed within six weeks of birth, with no limit to how many times you can bill this code. Note that you can bill **P008** if you assess the mother on the same day she comes in with her newborn baby.

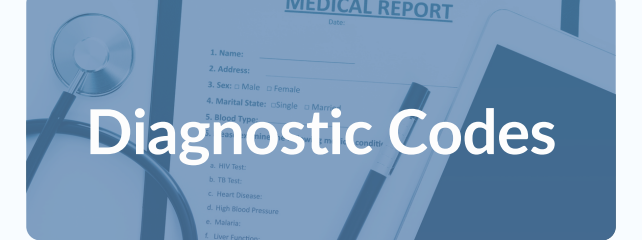
A002 - Enhanced Well Baby Visit

This visit must include age-appropriate developmental screening, with respect and concerns identified by the parent/guardian.



We recommend billing P003 + P005 on the first visit to ensure the patient's major assessments are done and ensure the best care. Our team can generate a list of patients for physicians who have missed billing P003 or P005 for their patients.





Diagnostic Codes

Diagnostic codes are a necessary component of claim submissions, as they indicate the medical reason for each patient visit. These codes ensure claims are processed correctly, help maintain accurate patient records, and contribute to optimized billing.

Given the significance of precise diagnoses, it's recommended to **avoid utilizing** generic diagnostic codes like '799—Non-specific Abnormal Findings: Other ill-defined conditions' during patient consultations. It's important to keep diagnoses as specific as possible for continuity.

Opting for more **specific diagnostic codes**, such as code '493' for asthma rather than '786' indicating general respiratory symptoms, will enhance the precision of your patient visits.



Knowing which diagnostic codes belong to acute and chronic conditions can help better define a patient's complexity by the Ministry.

Special Visit Premiums

If you are a physician visiting a patient at home, in a clinic, or in a long-term care facility, or if you possess certain specialties or sub-specialties enabling you to practice in a hospital, you might qualify for additional incentives on your claims.

Special Visit Premiums are additional fee codes that compensate physicians for unscheduled visits, providing care outside regular hours or attending to different departments within a hospital.

Doctors can claim three add-on codes while seeing a patient during a non-elective visit: Travel premium, first person seen and additional person seen.

Travel Premiums



First Person Seen



Add. Person Seen



Non-elective indicates that the physician was neither scheduled to be at the hospital/facility nor present there. **Elective** means that the physician had a scheduled appointment to see patients in the hospital or was working a scheduled round.

When billing Special Visit Premiums, since their purpose is for **non-elective visits only**, W-prefix and C-prefix consultations and assessments, as elective visits, are not eligible to be billed in conjunction with special visit premiums.

For example, codes like **W105, W102, W106, C007, C002** etc. are **not eligible** to be billed with special visit premiums since they fall under elective visits.



Only A-prefix assessments can be billed with special visit premiums. For example, A007 and other A-prefix assessments





A888 Emergency Department Equivalent

As part of meeting their After-Hours obligations, FHG physicians can provide eligible after-hours services during designated weekday evening hours **or** on weekends. If a FHG doctor provides after-hours services on the weekend or a statutory holiday, this would include the use of the **A888** billing code, which helps ensure physicians are fairly compensated for providing care during these extended hours.

A888 applies to emergency assessments provided outside of hospital emergency departments – including urgent care centres, walk-in clinics, and extended-hours clinics during weekends and holidays. This code is designed specifically for handling urgent, unscheduled care needs. When billing A888, a physician **cannot** have scheduled patients.

What constitutes “scheduled” is any pre-arranged appointment, regardless of timing. For instance, if a patient books at **9:00 AM** for an **11:00 AM** same-day appointment, this is considered scheduled and ineligible for A888.

When providing services to rostered patients, **Q012** can be added to the service to earn an extra 30% of the service claimed.

Virtual Care Codes

Virtual care has become an essential part of modern medical practice, allowing physicians to deliver timely, accessible care while improving efficiency in their day-to-day workflow. It enables better continuity with patients, reduces barriers to access, and provides flexibility in how care is delivered.

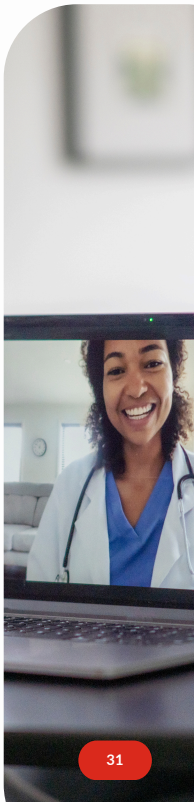
Comprehensive Virtual Care Services

Comprehensive Virtual Care is a service that can be billed if the patient has an existing/ongoing patient-physician relationship. This means that the patient is enrolled with the provider or with another provider within the same group, or the patient has been seen in person over the past **24 months**.

Modality Indicator Codes

When the service is provided virtually, the modality indicator codes **K300** and **K301** are added to patient visit fee codes and paid at a certain percentage.

Mode	Payable Amount
Telephone (K301)	85% of the fee amount
Video (K300)	100% of the fee amount



Limited Virtual Care Services

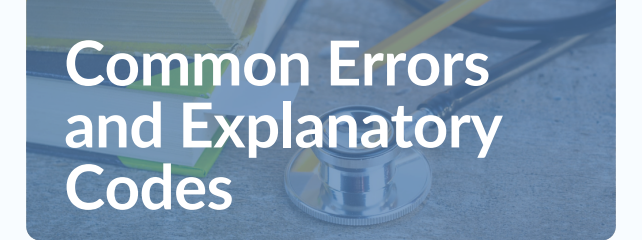
The Limited Virtual Care Services are billed for patients who are not enrolled and have not been seen in person in the preceding 24 months. These codes are not eligible to be billed with Q012.

Mode	Payable Amount
Telephone (A102)	\$15
Video (A101)	\$20



For more details and examples, download our [Virtual Care Billing Guide](#).





Common Errors and Explanatory Codes

Unpaid claims due to errors can result in significant amounts of revenue being left behind. The Ministry's error report can be unclear and confusing, making it hard for physicians to identify and address issues. Understanding the reasons behind rejections is key to resolving billing errors and protecting your practice's financial health.

Physicians can expect to see two kinds of alphanumeric errors in their monthly reports sent by the Ministry:

3-digit error codes: Error codes found in Error Reports

2-digit explanatory codes: Explanatory codes found in Remittance Advice (RA)

These are the top three errors that often get overlooked.

EH2 - Invalid version code

This error indicates an invalid version code attached to a patient's OHIP health card. To fix this error, verify that the version code is correct and up to date, then resubmit the claim.

AC4- Referring physician number required

This error indicates that the claim is missing the billing number of the referring physician. To fix this error, add the billing number to the claim.

M1 – Maximum fee allowed or Maximum number of services has been reached by same/any provider

This error indicates that the maximum fee allowed or the maximum number of services has been reached. To fix this error, you must resubmit an alternate fee code or write off the fee code if it is not applicable.

D3 – Service fee code not allowed in addition to visit fee

D3 indicates that a service fee code in your claim is not allowed in addition to the visit fee. This code is dependent on the specific claim that you submitted. You must review the code payment rules in the Schedule of Benefits and fix/settle the claim accordingly.



Our [Billing Care](#) service alleviates the burden of correcting and resubmitting errors, saving you time, preventing revenue loss, and allowing you to focus on quality patient care.



CHAPTER

03

Get the
Support
You Need



Expert Billing Support by DoctorCare

FHG physicians have a lot to keep track of when it comes to medical billing. Between providing comprehensive patient care, staying current with OHIP changes, and managing the administrative side of the practice, it can be difficult to ensure every eligible service is billed accurately and nothing is missed. Some of the most common billing challenges FHG physicians face include:

- **Missing premiums and incentives** — Eligible premiums, bonuses, and preventive care incentives can be overlooked when requirements aren't clearly understood or consistently tracked.
- **Billing accurately** — Choosing the right fee codes and meeting specific billing requirements can be challenging, particularly for complex or less frequently billed services.
- **Managing errors and rejected claims** — Unresolved errors can delay payment and result in missed revenue if claims aren't identified and resubmitted.
- **Finding missed revenue opportunities** — Without regular billing reviews, it can be difficult to know whether you're capturing everything you're eligible to receive.

For many FHG physicians, the challenge isn't simply knowing how to bill—it's finding the time and expertise to manage billing accurately and consistently, to continually adjust their approach.



Spend less time managing billing and more time focusing on your practice.

Billing Care takes the work out of OHIP billing by reviewing and submitting your claims, correcting and resubmitting errors, and helping your team stay on top of changing fee codes. With real-time billing insights through the Physician Portal and ongoing support from DoctorCare's billing experts, you can see your billing performance, identify missed opportunities, and have confidence that your claims are being managed accurately.

Ready to simplify your FHG billing?

Get started with a **free billing assessment** and see where your practice may be missing revenue.

[Book your assessment here](#)



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
- Financial reporting
- 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.

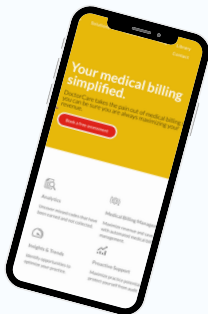
Uninsured Medical Billing Services

We offer a customizable platform to effectively manage uninsured medical service billing 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.



Visit doctorcare.ca