Ontario

Ministry of Health and Long-Term Care

Third Party Request for Personal Claims History Information

The purpose of this form is to authorize the Ministry of Health and Long-Term Care's disclosure of an individual's Personal Claims History (PCH) information *directly* to a third party.

The Ministry of Health and Long-Term Care (ministry) maintains a computer record of OHIP claims submitted by health care providers for billing and accounting purposes for a period of seven (7) years. The PCH information you are requesting is an extract of this computer record and is based on the patient health number the provider(s) submitted to the ministry with their claims for payment. *It is not a record of the medical services received by patients. To obtain a record of the services provided by specific provider(s), individuals should contact the provider(s) directly.*

The ministry may disclose the PCH information of an individual to a third party such as a law firm or insurance company ONLY IF the individual or an authorized Substitute Decision Maker (SDM) consents to the disclosure under Section 3. The ministry charges a $74 processing fee which must be enclosed with this form. If payment is not included, the form will be returned to the third party identified in Section 2.

The third party should submit the completed form and payment to:

Ministry of Health and Long-Term Care
OHIP Personal Health Information Office
49 Place d'Armes, 3rd Floor, Kingston ON K7L 5J3

If you require additional information to complete this form or have questions, please visit the ministry website at:
http://www.health.gov.on.ca/en/public/programs/ohip/third_party/default.aspx

Section 1 - Personal Claims History (PCH) Information Request

PCH information is being requested for:

Last Name *(as appears on Health Card)*	First Name *(as appears on Health Card)*	Second Name *(as appears on Health Card)*

Health Number	Version Code	Date of Birth *(yyyy/mm/dd)*

PCH information is being requested for the following specific period of time that does not exceed 7 years:

Start Date *(yyyy/mm/dd)*	End Date *(yyyy/mm/dd)*

Section 2 - Third Party Requester Information

Requester's Name	Requester's File Number
NATIONAL BANK INSURANCE	

Contact Person Last Name	Contact Person First Name	Email Address
		avbn.reclamation@bnc.ca

Mailing Address

Unit Number	Street Number	Street Name	PO Box, Rural Route, General Delivery
	1100	Boulevard Robert-Bourassa	5th Floor

City/Town	Province	Postal Code	Telephone Number
MONTREAL	ON	H3B 2G7	514 394-5000

Section 3 - Client Consent

This form must be signed and dated by the individual consenting to the disclosure of his or her PCH information to the third party identified in Section 2, or by an authorized SDM as described below. All changes or corrections to the content of this form must be initialed by the individual or the SDM.

- ☐ I am the requester and I am 12 years of age or older
- ☐ I am the requester's parent with custody, or a person lawfully entitled to consent on behalf of the requester who is under 12 years of age
- ☐ I am the requester's guardian of the person or property, or exercising a power of attorney for the requester who is an incapable adult
- ☐ The requester is deceased and I am an estate trustee or have assumed responsibility for the administration of the deceased's estate and I have provided a copy of the required documentation

Last Name	First Name

Signature	Date *(yyyy/mm/dd)*

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