ONTARIO HEALTH CARE RATIONING AUTHORIZATION FORM

DATE: _____

TO: **HON. KATHLEEN WYNNE, Premier of Ontario**
Phone: (416) 325-1941 Fax: (416) 325-9895

HON. DEB MATTHEWS, President of the Treasury Board of Ontario
Phone: (416) 327-2333 Fax: (416) 327-3790

HON. ERIC HOSKINS, Minister of Health and Long-Term Care of Ontario
Phone: (416) 327-4300 Fax: (416) 326-1571

FROM:

Please let me know if your Government has enough money to cover the following OHIP visit/test/diagnostic procedure/surgery **in full without your unilateral cuts**. Your prompt response is required to avoid any delay that may negatively impact upon patient care. If your Government does not have enough money, I will inform this patient that he or she is out of luck.

Patient Chart Number or Identifier (no personal ID):

REASON FOR SERVICE: _____

SERVICE(S) MEDICALLY NECESSARY NEEDED:

OHIP Fee Code	Description

MOHLTC Approval Response

☐ Yes ☐ No, reason for rejection: _____

NAME: _____ AUTHORIZED SIGNATURE: _____