Call Back Invoice

Interior Health

Name of Physician making the claim	
MSP Billing # of Physician making the claim	Contact information of physician making claim (phone number or email address)
Site	Name of Designated Group/Service
Is this submission for a Surgical Assist? ☐ Yes ☐ No	

IH Call Back reimbursement process:

1. Physician completes a Call Back Invoice detailing the call back
2. Physician ensures that he/she collects a Call Back Verification Form detailing the request from the physician or hospital staff member who initiated the call back request
3. The Physician forwards the Call Back Invoice and Call Back Verification forms to their designated Executive Medical Director for review and approval
4. Claims must be submitted within 30 days of the call
5. Once approved, the Executive Medical Director forwards both Forms onto IH Physician Compensation for payment

*Personal information on this form is collected under the **Freedom of Information and Protection of Privacy Act**. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the **Freedom of Information and Protection of Privacy Act**. If you have any questions about the collection, use or disclosure of this information, please contact Physician Human Resources Management at 250-952-3146.*

Date & Time call back received	Name of person initiating call back	Date & time physician physically attended the patient	Name of Patient	PHN of Patient	Facility where patient was attended	If Surgical Assist submission, please indicate the OR classification of patient	Indicate with a √ if approval is sought for payment on an exception basis
						☐ E1 ☐ E2 ☐ E3	

With respect to each of the above noted call backs:

1. The patient was not my patient or the patient of a colleague for whose patients I had accepted responsibility, and
2. At the time of the call back I was not on site at the Facility noted in the sixth column above, or scheduled to be on site, or scheduled to be next on site at a time when the patient's needs could be adequately met: Nor was I on call or being paid to be on site, on shift or otherwise available.

I am not receiving Isolation Allowance Fund payments and was not receiving such payments at the time of the above call back.

I authorize the Ministry of Health Services to release to the Health Authority named above any information related to the claims reflected on this invoice, excluding patient personal information (i.e. the name and personal health number of the patient), that, in the reasonable opinion of the Ministry, is relevant to assessing this claim, and if necessary, resolving any dispute over this claim through arbitration or otherwise. Such information will include, but not limited to compensation/billing information (excluding patient personal information).

Administrative Criteria

I certify that the above information is correct complete and there was no other suitable alternative available.		I certify that I have reviewed the clinical need, administrative criteria, there was no other suitable alternative available and I approve for payment	
Physician's Signature	Date	Executive Medical Director's Signature	Date
IHA Use ONLY Job Code:	Earning Code: 33'	.71.2070000	

Call Back Verification

Interior Health

Name of person initiating call back	*Personal information on this form is collected under the **Freedom of Information and Protection of Privacy Act**. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the **Freedom of Information and Protection of Privacy Act**. If you have any questions about the collection, use or disclosure of this information, please contact Physician Human Resources Management at 250-952-3146.*
Title of person initiating call back	

Date & Time call back was initiated	Name of physician who was called back	Name of Patient	PHN of Patient	Facility where patient was attended	Symptoms indicating emergency care was required

With respect to each of the above noted call backs:

1. I assessed the patient as requiring medical services on an emergency basis; and
2. Reasonable steps were taken to determine that the emergency medical services required by the patient could not have been provided (due to issues of competence or availability) by a physician who had on-going responsibility for the care of the patient (either directly or by virtue of his or her call group); by a physician who was on-call or by a physician who was being paid to be on site, on shift or otherwise available.

Administrative Criteria

I certify that the above information is correct complete and there was no other suitable alternative available.
Signature of Physician or IH Staff initiating call back
Date