



Saskatchewan
Medical Association

Fee Guide for Uninsured Services

Effective October 1, 2026



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“An Understanding of this Preamble is Essential for the Proper Interpretation of the Guide”

Preamble

I. Overview

This Guide provides SMA-suggested fees for uninsured medical services. For the purposes of this Guide, uninsured medical services are those that are not paid by the Medical Services Branch (MSB) of the Saskatchewan Ministry of Health in accordance with the Payment Schedule under the *Saskatchewan Medical Care Insurance Act*.

These services may be requested by the patient or by a third party interested in adjudicating the patient's fitness or eligibility for certain benefits. It is inappropriate to bill the MSB for uninsured services. A physician is entitled to charge either the patient for the service or the third party requesting the service. An appropriate record should be made of each uninsured service rendered.

The Guide is not binding on any physician. The Guide should be interpreted as a tool for determining reasonable relativity between fees for services of average complexity. It is assumed that physicians will, at all times, exercise responsible judgment in establishing their fees.

The basic principle of the Guide is that a physician is entitled to appropriate compensation for services rendered.

In circumstances where a fee might cause financial hardship to a patient, the physician may choose to reduce the fee.

When unusual time, skill, or attention is required in the management of any condition, the physician is entitled to a greater fee. In either case, where an individual adjustment is made, the physician is advised to provide the patient with an explanation.

The Guide is divided into three sections:

- Section **“A”** lists rates for general uninsured services and third-party requests;
- Section **“B”** lists services that are negotiated with agencies other than the Medical Services Branch;
- Section **“C”** provides general guidelines regarding uninsured fees for services with an equivalent fee code in the MSB Payment Schedule for insured services.

The suggested fee range for an uninsured service with an equivalent insured fee code is two to three times the insured rate (2x to 3x) listed in the MSB Payment Schedule for insured services.

II. Physicians' Guide to Direct Billing and Informing Patients

1. Ethics of Direct Billing

The Canadian Medical Association (CMA) Code of Ethics and Professionalism¹ articulates the ethical and professional commitments and responsibilities of the medical profession. In the context of direct billing for uninsured services, physicians should be guided by the following principles:

- Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.
- Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.
- Never exploit the patient for personal advantage.
- Take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to a third party when acting on behalf of a third party.
- Discuss professional fees for uninsured services with the patient and consider their ability to pay in determining fees.

Physicians are also encouraged to review the College of Physicians and Surgeons of Saskatchewan (CPSS) policy on uninsured services for additional professional guidance respecting uninsured billing practices².

2. Some Practical Guidelines

There are practical guidelines that physicians can follow when billing a patient directly to help make the process as convenient and efficient as possible.

A) Keep Patients Well Informed

Most difficulties between a physician and a patient arise from a lack of clear communication. Many patients simply do not realize that there are services not covered by the government, and they may become upset when presented with a bill.

To prevent this, physicians and their staff should ensure that patients are well informed about uninsured services and direct billing policies well in advance of receiving treatment.

Always ensure that fees have been discussed with the patient before providing the service, and consider the patient's ability to pay when determining fees.

The following are suggestions for informing patients about direct billing:

- Clearly display a poster outlining billing policies in the patient waiting area,
- Discuss fees when the patient books an appointment for an uninsured service,
- Advise patients of fees prior to providing the uninsured service,
- Provide patients with a fact sheet or pamphlet that includes information on direct billing.

¹ To access CMA Code of Ethics and Professionalism, visit: <https://www.cma.ca/cma-code-ethics-and-professionalism>

² To access CPSS policies on uninsured services, visit:

https://www.cps.sk.ca/IMIS/web/Physicians/Law_Guidance/Policies_Standards_Guidelines/PSG_Content/Uninsured_Services.aspx

B) Maintain Simple and Clear Office Policies and Procedures for Direct Billing

To establish consistent office policies, physicians should first determine:

- Which services will be billed directly to patients,
- The fees associated with those services,
- Any exemptions, such as for low-income patients,
- Bookkeeping and collection procedures.

A physician's office policies on direct billing must be specific and detailed so that staff and patients fully and clearly understand them. At the same time, they should allow sufficient flexibility to adapt to any unique or unexpected circumstances that may be encountered.

Once office policies have been established, they should be put in writing and distributed to office staff. Procedures should be in place to inform staff of any changes to these policies.

To minimize difficulties in direct billing, clinics should also:

- Maintain up-to-date accounts,
- Collect payment from patients at the point of service as often as possible,
- Follow up in an orderly and consistent manner.

C) Make Adjustments for Financial Burden

When calculating fees, physicians should consider the financial burden such charges might place on the patient and be prepared to adjust fees based on these considerations.

III. Policy Statement on Third-Party Requests and Uninsured Services

Most services provided by physicians are insured under the *Saskatchewan Medical Care Insurance Act* or paid by other agencies such as the Cancer Foundation, the Workers' Compensation Board, etc. However, some services provided by physicians are not insured. To clarify physicians' entitlements and responsibilities in this regard, the Saskatchewan Medical Association maintains that:

1. Physicians have a professional responsibility to expeditiously assist patients in obtaining those benefits to which they are legitimately entitled,
2. Physicians are entitled to reimbursement for the extra time and resources devoted to the provision of medical information to third parties and for providing any uninsured service,
3. Those parties requesting medical information, reports or certificates should be obliged to arrange for appropriate reimbursement,
4. Third parties who request medical information about individuals must be clear as to why they require the information and tailor any forms accordingly after consultation with the SMA about the design of their forms,
5. Third parties requesting information must ensure that the reason for the request is clearly communicated to the physician other than by word of mouth of the patient,
6. Requests from third parties for medical information should be accompanied by appropriate patient consent or other lawful authority for disclosure,

7. When providing medical information, physicians should not be expected to judge whether the subject patient is eligible for the benefits provided by the third party,
8. Physicians should not be expected to verify or manage absenteeism beyond providing relevant medical information,
9. In establishing fees for responses to third-party requests and for uninsured services, physicians are guided by, but not bound by, the SMA Uninsured Services Fee Guide,
10. The SMA is prepared to facilitate adjudication of disputes over fees charged by physicians for these services.

Unless otherwise specified in this Guide, physicians are encouraged to apply the same rules and principles set out in the "Assessment Rules" section of the MSB Payment Schedule for insured services³, when determining fees for uninsured services with an equivalent insured fee code. This includes rules respecting multiple services provided at the same encounter, hospital care, multiple surgical procedures, services supervised by physicians, and fee relativity between specialist and family physician services.

IV. Observations on Selected Services

1. Transfer of Medical Records⁴

Requests for information from the physician's office medical record may come from another physician, a patient, or from lawyers and other third parties. Each request merits a slightly different approach.

Requests from Physicians

It is rarely essential that a new physician obtain the patient's complete file from previous attending physicians, because most patients can recount the significant features of their past history. Therefore, a physician's request to another physician should state specifically what information is required (e.g., results of diagnostic procedures, therapeutic measures taken, response to therapy, etc.). In such cases, the physician might consider sending a written statement.

However, if a new physician sends a general blanket request, the previous attending physician has two options:

- send a photocopy or electronic copy of the documents on file; or
- send the entire chart and ask the new physician to make copies as needed and then return the original file (the physician should retain original files for a minimum of six years).

In most situations, there would be no charge for sending information to another physician.

Requests from Patients

The Saskatchewan *Health Information Protection Act (HIPA)* enshrines patients' rights to access their own health information, and allows physicians to charge a "reasonable fee" for this access.

When a patient asks for a copy of the medical record, one option is to suggest that the patient have their new physician request specific information. If the patient requests their own personal copy (and a growing number of patients are doing so), the physician should provide a copy (paper or electronic) and may charge the patient the fee(s) suggested in this Guide.

³ To access MSB Payment Schedule, visit: <https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/resources-for-health-care-businesses-and-career-development/establishing-and-operating-a-practice/physicians#payment-schedules-newsletters-bulletins>

⁴ To access CPSS guidelines on transfer of medical records, visit:

https://www.cps.sk.ca/imis/web/Physicians/Law_Guidance/Policies_Standards_Guidelines/PSG_Content/Transfer_of_Patient_Records.aspx

Requests from Lawyers

When a lawyer requests a copy of the medical chart, the first step is to ensure that there is a valid consent signed by the patient to be placed on file. The next step is to offer to provide a report addressing the lawyer's specific questions.

If that offer is not accepted by the lawyer, send a photocopy of the chart and charge the lawyer as suggested in the SMA Fee Guide.

It is helpful to note that such fees are almost always passed on to the patient. The fee(s) charged to lawyers should not exceed what the patient would have been charged for direct access to the information.

The *Health Information Protection Act* requires that physicians (and other information trustees) respond to information requests within a reasonable time frame. Saskatchewan's Privacy Commissioner has informally defined "within 30 days" as a reasonable time frame for responding to non-urgent requests.

2. Missed Appointments

Charging for missed appointments is not a general occurrence, but there are circumstances that would justify such charges. Patients should be advised in advance under what circumstances charges for missed appointments may apply.

3. Prescription Renewals by Telephone

Telephone prescription renewals initiated by a pharmacist are considered insured services (unless provided to an RCMP or other uninsured beneficiary).

Patient-initiated telephone prescription renewals are considered uninsured services. Physicians are encouraged to exercise professional judgment in determining whether to charge for this service, as such charges may be subject to scrutiny.

As with missed appointments, patients should be advised in advance if a charge will be levied.

4. Uninsured Services Provided at the Same Time as Insured Services

While assessing a patient at the request of a third party for an uninsured service, it may become apparent that the patient requires medical care. Providing necessary medical care would be insured and it would be acceptable to submit a claim to the Medical Services Branch for those services. However, the portion of the service relating to compliance with the third party's request, such as completion of a report or certificate, remains uninsured. The physician is entitled to charge separately for that portion.

It is expected that physicians will not charge for any of the following in addition to insured fees for any medical services provided:

- writing a prescription
- a referral note to another physician
- completion of a standard requisition form for a diagnostic or therapeutic service
- completion of patient records

Charges for long-distance telephone calls related to referrals to other physicians may be billed to the patient.

5. Critical Condition Good Faith (CCGF) Program

For certain eligible urgent or emergent in-hospital services provided to Canadian residents without a valid health card at the time of service, reimbursement may be available through the SMA's Critical Condition Good Faith (CCGF) program.

Eligible physicians may submit an application, in accordance with the program guidelines and eligibility requirements⁵, to the SMA Economics department (economics@sma.sk.ca).

V. Unlisted Services

When no fee is listed for a service and the service cannot be readily compared to one that is listed, the physician may submit a request for a new listing to the SMA Uninsured Services Committee through the SMA Economics department (economics@sma.sk.ca).

VI. Disputed Fees

All cases requiring advice regarding a dispute over fees or over the interpretation of this preamble should be referred to the Saskatchewan Medical Association.

⁵ To access CCGF guidelines and application form, visit: <https://www.sma.sk.ca/critical-condition-good-faith-coverage/>

Section A: Uninsured Services Without Equivalent Insured Fee Codes

The following is a categorized list of services for which physicians are entitled to charge, along with SMA-suggested fees. The list is not exhaustive.

I. Charges Based on Cost

This section includes services provided to patients for which reimbursement is calculated based on the actual cost to the physician. **The charge may include the actual invoice cost, applicable taxes, staff time, and other overhead costs.**

821A ⁶	Long distance telephone calls on behalf of a patient	Cost
822A	Medication by injection (hyposensitization serum, immunization, B12, etc.)	Cost
823A	Bandages, splints, IUD or other materials	Cost
824A	Uninsured tray services	Cost

II. Charges Based on Independent Consideration

To determine a fee for third party or uninsured services, physicians may be guided by the fees listed in this Guide. To determine the fee for a service not listed in this Guide or to establish a fee independently, physicians may consider the following factors:

- the nature and complexity of the matter;
- the experience and expertise required of the physician;
- time spent with and/or on behalf of the patient;
- the related office overhead costs.

Services with fees set on an individual consideration basis include, but are not limited to:

- Preparation and transfer of a patient's health record at the request of the patient or the patient's representative. The physician may charge for any time spent in preparing information for transfer, in addition to associated office overhead costs,
- Surgery to alter appearance other than for abnormalities due to disease, trauma or congenital defect,
- Anaesthetic service rendered for the provision of uninsured surgical or dental services,
- Acupuncture procedures,
- Routine examination of eyes for patients over age 17,
- Electrolysis,
- Reversal of sterilization,
- Implantation of a penile prosthesis,
- Removal of minor skin lesions by cryotherapy, laser, cautery or curettage (except actinic keratoses, pyogenic granuloma, keratoacanthoma or bleeding lesions),
- Dye-tuned laser ablation of cutaneous lesions (except facial port-wine stains in patients under age 18),
- Injection of asymptomatic varicose veins and spider telangiectasia,
- Travel beyond the usual geographic area of practice to provide a medical service (insured or uninsured),
- Services that are part of uninsured group screening programs,

⁶ These alphanumeric codes have been changed from 801A-804A to 821A-824A.

SECTION A: UNINSURED SERVICES WITHOUT EQUIVALENT INSURED FEE CODES

- Visit or procedure services related to surveys or research,
- Providing or refilling a prescription by telephone when requested by the patient or the patient's representative, and no concomitant insured service is provided,
- Missed appointments for visits or procedures,
- Any other services or procedures not insured/paid by Saskatchewan Health.

Professional Work Other Than Direct Patient Care

- 917A Includes administrative, advisory or committee work, and other professional work not covered by a specific fee listed below
- per 5 minutes or portion thereof \$35.00*

Transfer of Patient Paper Records

- 511A Photocopying/printing of records, Base fee \$40.00*
- 512A - plus per page \$0.30*

Transfer of Patient Electronic Records

- 513A Base fee \$40.00*
- Where electronic storage media (e.g., USB devices) are required to transfer records, physicians may charge the patient the actual cost of such devices, in addition to the base fee.

- 610A⁷ Physician time taken in reviewing the request/information or reviewing the chart, if necessary
- per 5 minutes or portion thereof \$35.00*

Note: 610A should not be billed when the patient has requested a complete copy of the chart, unless there are circumstances, as set out in section 38(1) of the HIPA, in which a patient may be denied access to all or part of their medical record.

*** Physicians may choose to waive all or part of the fee where it is fair and reasonable to do so.**

Missed Appointments

- 516A For an in-person or virtual care visit, or procedure service (if 24 hours' notice of cancellation is not given) Up to 50% of listed fee

Medical Advice to a Patient

- 517A by telephone (including patient telephone prescription renewal)
- per 5 minutes or portion thereof \$35.00*
- 518A by letter, per 5 minutes or portion thereof \$35.00*

Note: Fee code 517A may be used when a specialty-specific virtual care service fee does not apply.

⁷ This alphanumeric code has been changed from 810A to 610A.

SECTION A: UNINSURED SERVICES WITHOUT EQUIVALENT INSURED FEE CODES

Time Spent on a Patient's Behalf

- 519A Representation with an allied health professional, health care facility, social service agency, etc.
- per 5 minutes or portion thereof \$35.00*
- 524A Case conference – per 5 minutes or portion thereof \$35.00*

Physician Travel

- 525A - by commercial carrier Cost
- 526A - by personal vehicle (per km) \$0.7641
- Plus**
- time - per one hour or portion thereof \$85.00
- Plus**
- Expense Allowance
- In province – per day \$80.00
- In province – overnight allowance..... \$250.00
- Out-of-province – per day \$300.00

Telephone Attendance

- 55A - per 5 minutes or portion thereof \$35.00*

Acupuncture

- 528A - per visit – per 5 minutes or portion thereof \$35.00*

*** Physicians may choose to waive all or part of the fee where it is fair and reasonable to do so.**

III. Response to a Request for Information by Third Parties

A third-party service is any service provided for a patient that is necessary to satisfy the requirements of a party other than the patient.

1. A few third-party services are paid by the Medical Services Branch (MSB) or by other agencies at negotiated rates. These services are listed in "Section B" of this Guide.
2. Other third-party services that are not insured are also listed in this Guide. All medical services, including assessments, examinations, diagnostic tests and/or reports for these requests, are uninsured. Physicians are entitled to reimbursement for the time and resources devoted to the provision of these services. Examples of third-party services include:

Certification of Health Status for:

- Admission to, or continued attendance in, day care, pre-school, elementary and secondary school, community college, technical institute, university or other educational institution,
- Admission to, or continued attendance in, a camp or recreational/athletic program,
- Issuance of a driver's, pilot's, or other license,
- Obtaining or continuing employment, including pre-employment or annual/periodic medical examinations,
- Meeting the requirements of provincial legislation or accessing the benefits of provincial health or social programs (e.g., community treatment services),
- Application for, or continuation of, life, disability or other insurance coverage,
- Bank loan insurance,
- Injury report to Hockey Canada,
- Assessment of claims for medical services provided abroad,
- Abilities Council special parking permit,
- Meeting the requirements of, or accessing the benefits of, certain services provided by health care facilities (e.g., outpatient dietary counselling, physiotherapy, etc.),
- Continuing Care Assessment Form or Instruction Form,
- Providing information to the Coroner's Office.

Certification of Illness for:

- Sick notes for employment or return to work,
- Sick notes for school, day care or recreation/athletic programs,
- Meeting the requirements of federal legislation or accessing the benefits of federal health or social programs (e.g., Employment Insurance, Canada Revenue Agency Disability Tax Credit, disability or maternity benefits),
- Entitlement to benefits under other disability insurance plans,
- Airfare cancellation,
- Student loan relief,

Verification of Death for:

- Validation of a life insurance claim.

Legal reports and medical testimony in court.

SECTION A: UNINSURED SERVICES WITHOUT EQUIVALENT INSURED FEE CODES

Note: Where completion of a report requires a medical assessment of the patient, the physician is entitled to bill the appropriate visit fee in addition to a report fee to the third party (unless the services have been bundled, such as with the commercial drivers' medical fee).

Providing Medical Information

The total fee for a report depends on the length of the form and the time taken to complete it.

Photocopy of Medical Records

527A - reply to an inquiry by submission of photocopy of a consultation or other written report See 610A
(this will not normally be charged when photocopies are attached to written reports or report forms)

529A Completion of form or brief written statement (per 5 minutes or portion thereof) \$35.00*

565A⁸ Written letter (per 5 minutes or portion thereof) \$35.00*

Commercial Driver's Medical

605A⁹ Assessment and completion of form \$194.00-\$304.00
The final amount is based on whether a partial or a complete assessment is conducted.

606A¹⁰ Form only \$84.00

*** Physicians may choose to waive all or part of the fee where it is fair and reasonable to do so.**

⁸ This alphanumeric code has been changed from 535A to 565A.

⁹ This alphanumeric code has been changed from 805A to 605A.

¹⁰ This alphanumeric code has been changed from 806A to 606A.

IV. Medical-Legal Services

It is important to understand why a lawyer is asking for a medical report or a medical-legal opinion and specifically what information is required. If the lawyer's request is unclear, the physician should contact the lawyer to seek clarification. If payment for the report is not assured, the lawyer should be contacted prior to responding to the request.

1. Medical Reports

560A Completion of form or brief statement (per 5 minutes or portion thereof) \$35.00

561A Written letter (per 5 minutes or portion thereof) \$35.00

Note: This is a factual report, based on a review of office and/or hospital records, concerning the patient's past health or current condition. The report may be submitted to a lawyer, insurance company, or other third parties.

563A Medical-Legal Report \$840.00
 - if more than one hour of physician's time,
 for each subsequent 5 minutes or portion thereof, add 917A \$35.00

Note: This is a factual summary of the history, symptomatology, investigation, therapy, results and present condition. It may contain an estimate of the date that the person could return to work and perhaps some comment as to the likelihood of permanent disability.

564A Medical-Legal Opinion \$945.00
 - if more than one hour of physician's time,
 for each subsequent 5 minutes or portion thereof, add 917A \$35.00

Note: This is a medical-legal report in addition to an expert opinion concerning such matters as:

- cause and effect
- long-term consequences
- possible complications
- extent or percentage of disability
- relationship of condition to factors in the work situation

This service involves the exercise of expert knowledge and judgment with respect to the medical facts and findings including a detailed prognosis for the person affected.

2. Medical Testimony in Court

These codes are to be billed when Saskatchewan Justice tariff rates do not apply. Certain fees are paid by Saskatchewan Justice at rates negotiated with the SMA and prescribed in rules of Court (see page 15).

I) Attending Physician

566A Preparation time – per 5 minutes or portion thereof \$35.00

567A Court attendance or pre-trial briefing – first hour or portion thereof \$735.00

568A - Time in court after the first hour, per 15 minutes \$230.00

SECTION A: UNINSURED SERVICES WITHOUT EQUIVALENT INSURED FEE CODES

II) Physician Called As Expert

569A	Preparation time - per 5 minutes or portion thereof	\$35.00
570A	Court attendance - first hour or portion thereof	\$945.00
571A	- Time in court after the first hour, per 15 minutes	\$230.00
572A	Failure to give two working days' notice of a court adjournment or cancellation	\$945.00

Note: Out-of-pocket expenses for meals, accommodation and travel should be billed in addition at cost.

Section B: Third-Party Services at Rates Negotiated with the SMA

This section consists of services that may be requested by a variety of Provincial and Federal agencies. The services listed in this section are not insured under the *Medical Care Insurance Act* and are therefore not paid by MSB. They are, however, paid by the agencies that request these services at rates negotiated with the SMA. Unless otherwise noted, these services should be charged directly to the agency requesting the service.

I. Saskatchewan Justice

Appearance as a Material Witness for the Crown in Criminal Proceedings

Testimony

First court appearance

589A	- first hour or part of the first hour	\$250.00
	- for each subsequent 15 minutes or major portion thereof	\$60.00

Subsequent court appearance

590A	- first hour or part of the first hour	\$250.00
	- for each subsequent 15 minutes or major portion thereof	\$60.00

(i) Payment for preparation, pretrial briefing and waiting time is included in the testimony fee. Travel expenses will be fully reimbursed.

(ii) Fees for payment as an "expert" witness are negotiable.

(iii) Cancellation Notice	\$200.00
A flat fee will be paid if the practitioner's office is not notified of an adjournment or cancellation at least two business days before the scheduled court appearance.	

Reimbursement of Expenses

580A	(i) Meal allowances (at Public Service Commission rates, effective July 14, 2024)	
	- breakfast	\$16.00
	- lunch	\$23.00
	- supper	\$31.00
581A	(ii) Accommodation	
	hotel (recommended rate/night; receipt required)	\$125.00-\$150.00
	private (recommended rate/night)	\$35.00
582A	(iii) Travel - commercial carrier (receipt required)	Cost
	- private vehicle, per km (at Public Service Commission rates, effective October 1, 2026)	
	- below 54 th parallel	\$0.7641
	- above 54 th parallel	\$0.8228
	- taxi (receipt required)	Cost

SECTION B: THIRD-PARTY SERVICES AT RATES NEGOTIATED WITH THE SMA

Medical Documentation – requested by Lawyer

- 583A (i) Letter \$150.00
This is a factual report on past health and/or current condition
based on review of office and/or hospital records,
which summarizes the history, symptomatology, investigation, therapy, and results.
- 585A (ii) Report (opinion) \$300.00

This is an expert opinion concerning such matters as: cause and effect, long-term consequences, possible complications, and extent or percentage of disability. It involves the exercise of expert knowledge and judgment including a detailed prognosis, and may contain some comment as to the likelihood of permanent disability.

Note: Medical documentation fees are negotiable with the requesting lawyer if the report is complex.

Appearance as a Witness in a Civil Proceeding

Payment arrangements in a civil proceeding should be discussed/negotiated with the lawyer requesting your services. If a suitable fee cannot be agreed upon, you may be subpoenaed in which case the following rates will be paid for your appearance in court.

- Professional witness \$100.00 per half day
Consultant to give expert testimony \$200.00 per half day

A reasonable fee for preparation time and a reasonable fee in the event of adjournment or settlement of the action prior to testimony in Court is allowed at the discretion of the taxing officer.

If a medical report arising out of an examination is admitted in evidence, and the physician or surgeon who made the report does not personally attend to give evidence, the fee payable to the physician or surgeon who made the report is \$200.00.

Expenses will be paid on submission of receipts for necessary travel, accommodation and meals.

Payment Arrangements:

Provincial Court

In Regina and Saskatoon, submit claims for expenses, reports and court appearances to the prosecution office requesting your services. In all other areas of the province, submit your claims to the RCMP or city police officer who requested your testimony.

Court of King's Bench

In all areas across Saskatchewan, submit claims for expenses, reports and court appearances to the prosecution office requesting your services.

For information contact: Public Prosecutions
Saskatchewan Justice
300-1874 Scarth Street
Regina, SK S4P 3V7

Telephone: 306-787-5490

II. Police Services

Examination Following a Suspected Sexual Assault

Bill the MSB under Code 39A for medical documentation and initial assessment and treatment.

- 591A Additional time taken to gather and provide evidence for the investigating officer
- per 15 minutes or portion thereof \$45.00
(charge to the police officer’s local detachment)

Collection of Sample for Blood Alcohol Determination

Any medical services provided to a driver injured in a motor vehicle accident are insured by MSB.

An additional fee for drawing a blood alcohol sample may be submitted to the local detachment of the investigating police officer as follows:

- 592A Collection of blood sample and completion of forms for alcohol level determination \$55.00
- plus 917A for any detention
- plus appropriate surcharge when called specially to collect the sample

III. Department of Social Services – Child and Family Services Branch

All services are paid at rates equivalent to Saskatchewan Justice fees for criminal proceedings.

Submit to: Department of Social Services
Child and Family Services Branch
1920 Broad Street
Regina, SK S4P 3V6

IV. Workers' Compensation Board (WCB)

Physician service fees and fee codes for reporting:

All fees will be adjusted annually using the Family Medicine (FM) composite index for fee-for-service (FFS) payments negotiated by the SMA and the Saskatchewan Ministry of Health.

Service	Fee Code	Effective April 1, 2024	Effective April 1, 2025	Effective April 1, 2026
Reports				
Initial (PPI)	650	\$75.53	\$77.06	\$77.06
- If submitted using WCB's online services, add:	651	\$15.92	\$16.25	\$16.25
Progress (PPP)	660	\$46.92	\$47.87	\$47.87
- If submitted using WCB's online services, add:	661	\$15.92	\$16.25	\$16.25
Complicated Consultations (Specialist or GP Specialist)¹, add:	119	\$120.71	\$123.16	\$123.16
Special Opinion, on Request (relationship or percentage of functional impairment), add:	97	\$301.71	\$307.81	\$307.81
Research Fee when requested by the WCB (per 10 minutes)				
- Specialist	178	\$60.40	\$61.64	\$61.64
- General Practitioner	177	\$54.39	\$55.51	\$55.51
Telephone Consultations²				
First 10 minutes:				
- Specialist	126	\$60.42	\$61.64	\$61.64
- General Practitioner	1126	\$54.41	\$55.51	\$55.51
10 to 15 minutes:				
- Specialist	128	\$80.47	\$82.10	\$82.10
- General Practitioner	1128	\$72.18	\$73.65	\$73.65
Each additional 15 minutes:				
- Specialist	164	\$80.47	\$82.10	\$82.10
- General Practitioner	1164	\$72.18	\$73.65	\$73.65
RHCS4 – Treatment Implementation	179	\$42.11	\$42.97	\$42.97
If received by the WCB within five days of the report request ³ , add:		\$25.00	\$25.00	\$25.00

¹ This refers to conditions involving more than one area of the body or chronic clients (those with injuries older than 12 weeks).

² Phone conversations are initiated by the WCB or a health-care provider currently treating the worker. Include a synopsis of the consultation in the patient's chart.

³ The amount payable for completion of the RHCS4 does not increase due to the FM index.

SECTION B: THIRD-PARTY SERVICES AT RATES NEGOTIATED WITH THE SMA

Physician service fees and fee codes not covered by the Ministry of Health:

Service	Fee Code	Effective April 1, 2024	Effective April 1, 2025	Effective April 1, 2026
Counselling on Return-to-Work (RTW) and Completion of an employer-provided restrictions/functional abilities/RTW form¹ (per 10 minutes or major portion)	640	\$57.48	\$58.64	\$58.64
Hospital Management² (per hospital stay)	199	\$159.13	\$162.36	\$162.36
Traumatic Brain Injury Consultation				
Chair	89	\$1,259.02	\$1,284.50	\$1,284.50
- Actual time spent in excess of 2.5 hours (per hour)	1189	\$504.11	\$514.31	\$514.31
Member	189	\$1,006.96	\$1,027.34	\$1,027.34
- Actual time spent in excess of 2.5 hours (per hour)	1089	\$402.27	\$410.41	\$410.41
Cardiac (per hour)				
Chair	42	\$504.11	\$514.31	\$514.31
Member	142	\$402.27	\$410.41	\$410.41
Cardiopulmonary – Medical Consultant				
Chair	5	\$1,511.08	\$1,541.66	\$1,541.66
- Actual time spent in excess of 2.5 hours (per hour)	1150	\$504.11	\$514.31	\$514.31
Member	150	\$1,206.82	\$1,232.24	\$1,232.24
- Actual time spent in excess of 2.5 hours (per hour)	1050	\$402.27	\$410.41	\$410.41
Medical Review Panel				
Chair	15	\$2,012.64	\$2,053.37	\$2,053.37
- Actual time spent in excess of 2.5 hours (per hour)	1115	\$504.11	\$514.31	\$514.31
Member	1015	\$1,610.37	\$1,642.95	\$1,642.95
- Actual time spent in excess of 2.5 hours (per hour)	1215	\$402.27	\$410.41	\$410.41
Medical Board				
Member	190	\$1,006.96	\$1,027.34	\$1,027.34
- Actual time spent in excess of 2.5 hours (per hour)	1190	\$402.27	\$410.41	\$410.41
Chaperone Fee (per 15 minutes)	85	\$100.65	\$102.68	\$102.68

Note: The Workers' Compensation Board reserves the right to withhold payment for incomplete or illegible reports received.

Contact information is provided on the next page.

¹ This applies to patient counselling regarding early return to work and completion of an employer provided return-to work/restrictions/abilities form. It is billable at any session where an employer provided form is completed and returned to the employer. The visit fee and WCB report form are also billable at the same visit.

² Hospital management is billed by the most responsible physician and/or physician completing discharge summary, for inpatient hospital stays. It includes discussion with patient regarding expectations for recovery and return to work. Hospital management is billed at or near time of discharge, with notation in patient's chart.

SECTION B: THIRD-PARTY SERVICES AT RATES NEGOTIATED WITH THE SMA

Submit to: Workers' Compensation Board
Health Care Services
200-1881 Scarth Street
Regina, SK S4P 4L1

Phone: 306-787-4370
Toll-Free Phone: 1-800-667-7590
Fax: 306-787-4311
Toll-Free Fax: 1-888-844-7773

V. Saskatchewan Power (SaskPower)

850A¹ Completion of SaskPower Practitioner’s Report Form P148 \$40.00

Please return forms and submit claims to:

Submit to: Saskatchewan Power
Return to Work
10 SE, 2025 Victoria Avenue
Regina, SK S4P 0S1

Telephone: 306-566-2416
Fax: 306-566-2406

VI. RCMP Personnel

RCMP Health Services pays at the rates listed in the SMA Uninsured Services Fee Guide. The fee includes reporting relevant clinical findings on the form, which becomes part of the officer’s medical file. Submit on RCMP Form 2135, Clinical Report and Account Form, to:

Submit to: RCMP Health Services
Box 6500
Regina, SK S4P 3J7

Telephone: 306-780-3836

¹ This alphanumeric code has been changed from 800A to 850A.

VII. Saskatchewan Government Insurance (SGI)

Forms – Including SGI Injury Claims

Practitioner's Initial Report – for a complete, legible report:

- received within 30 days \$50.00
- received within 7 calendar days after the visit or 14 days after request from the adjuster \$60.00

Individual Written Rehabilitation Plan Form	\$20.00
SGI Claimant Assessment Form	\$20.00
Practitioner Pre-assessment Form	\$20.00

Case Conferences

These will be paid as per the telephone consultation fees. Individual consideration will apply if travel outside the practitioner's community is required.

The physician should bill the adjuster for the call.

Request for Information

Telephone Consultation:

0 to 10 minutes	\$20.00
10 to 15 minutes	\$38.50
each subsequent 15 minutes (917A)	\$38.50

Photocopy of Report/Consult	610A/512A
Form or brief report	529A
Written letter - factual statement of patient's condition	565A
Medical-legal report	563A
Medical-legal opinion	564A

If preparation of the report for 563A or 564A requires more than one hour, payment for additional time is based on 917A.

SGI officials are instructed to be very specific in their requests for reports and to indicate which code will be paid. If the fee submitted exceeds the code indicated, the physician may be asked for an explanation.

Follow-up reports should be submitted directly to SGI and only on request from an SGI official. Lawyers may obtain information from SGI.

Submit to: Saskatchewan Government Insurance (SGI)
2260 - 11th Avenue
Regina, SK S4P 0J9

SGI Medical Review Unit (former SGI Driver Fitness Review)

Note: SGI also reimburses physicians for requested drivers' medicals. **See codes 70A/71A/74A in the MSB Payment Schedule for insured services.**

VIII. Veterans Affairs Canada

The Department of Veterans Affairs (DVA) has declared that it will pay physicians at Medical Services Branch Payment Schedule rates.

Medical reports provided by a patient in support of a request for a benefit can be reimbursed at the following rates if supported by a receipt/invoice from the physician.

Source and Form of Information

Prescription only with no or minor explanation, e.g., medication required for lower back pain	Nil
Phone call with physician's office (not physician) to obtain information	Nil
Phone conversation with physician	\$10.00 per call
- information provided verbally to support a request for Special Authorization payment of a drug or details provided regarding the drug utilization pattern of a client.	
Completion of a VAC form	\$30.00
- information provided in writing on a VAC supplied form to support a request for Special Authorization payment of a drug or details provided regarding the drug utilization pattern of a client.	
1 st page of original report by a General Practitioner	\$30.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.	
1 st page of original report by a Specialist	\$50.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.	
Subsequent pages of original report by a GP or Specialist	\$20.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.	
Photocopied information	\$15.00
- copy of physician's note or report to or from a third party. This is provided to support a request for Special Authorization payment of a drug or details provided regarding the drug utilization pattern of a client.	
Renewal of prescription by telephone (when fee not covered by province)	\$5.00
physician call to request authorization for Special Authorization benefits.	

SECTION B: THIRD-PARTY SERVICES AT RATES NEGOTIATED WITH THE SMA

DVA beneficiaries are only those veterans who have been declared eligible for a pension related to a specified disability.

If there is any reason to believe that a veteran has been declared eligible, submit to DVA on the Saskatchewan Blue Cross form provided in your supplier kit.

If the form is inadvertently sent to DVA and they are not responsible for the claim, they will forward it on to MSB rather than return it to you. If MSB receives a claim that is DVA responsibility, they will return it to you.

If you want to register as a supplier or if you require billing forms, please contact Saskatchewan Blue Cross at 1-800-301-6102, or in Saskatoon at 306-244-5839.

Submit to: Veterans Affairs Canada
PO Box 6050
Winnipeg, MB R3C 4G5

Telephone: 1-866-522-2122

IX. Canadian Forces

The Canadian Forces have declared that they will pay physicians at Medical Services Branch Payment Schedule rates.

Claims administration is handled through Saskatchewan Blue Cross, similar to the processes used for DVA claims. If you require billing forms or further information, please contact Saskatchewan Blue Cross directly at:

Saskatchewan Blue Cross
P.O. Box 4030
Saskatoon, SK S7K 3T2

Telephone:
Toll-Free: 1-800-301-6102
Saskatoon: 306-244-5839

X. Canada Post

550A Physician’s Modified Work Information Sheet Use 529A

Submit to: Manulife Financial
 2220 Laurier Avenue West, Suite 400
 Ottawa, ON K1P 5Z9

XI. Canada Pension Plan (CPP)

CPP Disability Medical Report Form:

Service Canada reimburses physicians for completing certain medical forms and reports related to CPP disability benefits. Effective October 1, 2026, Service Canada reimburses up to \$175 for completion of the Initial Medical Report for CPP Disability Benefits (ISP-2519), or the Terminal Illness Medical Attestation (ISP-2530B).

The amount was established in consultation with the CMA and reflects an estimated completion time of 43 minutes.

The federal government has issued a guideline to assist physicians in responding to specific requests from CPP to provide a narrative report regarding a patient's claim for disability benefits. The guideline allows for payment up to a maximum of \$150.00 for these detailed reports (see 552A).

The following rates, provided by Service Canada, are intended to assist physicians in determining the appropriate fees.

Billing for Medical Reports

Service Canada will reimburse physicians upon receipt of their invoice.

553A	Initial Medical Report for Disability Benefit (ISP-2519) up to \$175.00 - or Terminal Illness Medical Attestation form (ISP-2530B)
554A	Reassessment Medical Report up to \$25.00
555A	"Scannable Impairment Evaluation" and the "Medical Report – Recurrence of the Same Medical Problem" (ISP-2525) up to \$50.00 each
552A	A complete and detailed narrative report that involves more extensive chart review and medical report preparation up to \$150.00

Notes:

- The completed medical forms and invoices should be submitted to the Service Canada office identified on the forms.
- Physicians may also bill patients for the difference between the Service Canada payment rate and the physician's normal rate for a similar service (see codes 527A/565A). The patient's ability to pay should be considered.
- CPP has indicated that payment may be processed more quickly if the time required to complete the request is noted on the bill.
- Occasionally, CPP requests independent medical consultations or functional capacity evaluations during the application process, or to determine continuing eligibility. Service Canada pays the specialist or facility directly for these examinations.
- Fees mentioned in this section are set in consultation with the Canadian Medical Association (CMA) and are subject to change.
- Other disability forms and reports, such as the Canada Revenue Agency (CRA) Disability Tax Credit (DTC) form, should be billed directly to the patient (see 529A/565A).

Section C: Uninsured Services with an Equivalent Insured Fee Code

For certain uninsured services, there is an equivalent fee code in the *MSB Payment Schedule for Insured Services*. In such cases, the SMA-suggested fee range for the uninsured service is two to three times the insured rate (2x to 3x) listed in the *Payment Schedule*.

This multiplier is intended to provide physicians with a suggested fee range for uninsured services of average complexity that correspond to insured services. It is a guide only and is not binding on any physician. Physicians remain responsible for exercising professional judgment in establishing their fees.

The suggested fee range for an uninsured service with an equivalent insured fee code is two to three times the insured rate (2x to 3x) listed in the MSB Payment Schedule for insured services.

Example 1: If the insured fee for a Partial Assessment (5B) is \$44.10, the suggested uninsured fee range would be \$88.20 to \$132.30

Example 2: If the insured fee for a Low Complexity Anesthetic (501H) is \$52.40, the suggested uninsured fee range would be \$104.80 to \$157.20

General Principles

- This suggestion applies only where the uninsured service can reasonably be matched to an equivalent insured fee code in the MSB Payment Schedule.
- The suggestion is intended to assist physicians in establishing fair and consistent fees for uninsured services; it does not set a fixed or mandatory charge.
- As with the rest of this Guide, physicians may choose to reduce a fee where payment would create financial hardship for a patient, or to charge a greater fee where unusual time, skill, or attention is required.
- Physicians should inform the patient or third party of the fee before providing the uninsured service. An appropriate record should be made of each uninsured service rendered.
- If an encounter includes both an insured and an uninsured component, only the insured portion may be submitted to the Medical Services Branch (MSB). The uninsured portion remains separately billable to the patient or requesting third party, as appropriate.
- Where another fee is specifically listed elsewhere in this Guide, or where a fee has been negotiated with a third party, that fee should apply instead of the general multiplier described in this section.

Physicians should inform the patient or third party of the fee before providing the uninsured service. Physicians may choose to reduce a fee where payment would create financial hardship for a patient.