Property and Casualty - Auto Bulletins

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Monitoring and Enforcement Bulletins

Licensing Changes Bulletins

Bulletins by Sector

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Bulletin

No. A-15/03

Property & Casualty

- Auto

The Designated Assessment Centre Selection Process at the Financial Services Commission of Ontario, and Revised Accident Benefits Claims Form (OCF-22) Application for Approval of an Assessment or Examination

To the attention of all insurance companies licensed

to transact automobile insurance in Ontario

As outlined in Bulletin No. A-11/03, there is a new process for selecting a Designated Assessment Centre (DAC) under section 53 of the Statutory Accident Benefits Schedule (SABS) as of October 1, 2003. With this Bulletin, a Guideline is being issued that describes the process to be used to request that the Superintendent select a DAC when required by the parties in a dispute.

This DAC Selection Guideline must be used for all referrals to DACs on or after **October 1, 2003, when the parties are unable to agree on a DAC to conduct the assessment. This Guideline and section 53 of the SABS apply to all such referrals regardless of the date of the accident.**

Under the SABS, the insurer and the claimant should first try to agree on a DAC to conduct an assessment. Under

this agreement process, the insurer shall indicate to the claimant which DACs are qualified to conduct the required assessment within the respective geographical limits. The parties would then have two business days to agree on a DAC.

If the parties are unable to agree on a DAC within this time-frame, the insurer shall contact FSCO, in accordance with the attached Guideline, and request that a DAC be selected.

It is FSCO's expectation that, during this agreement process, insurance companies and claimants will be mindful of the need to reduce costs and increase consumer convenience by agreeing to a DAC that is within a reasonable distance from the claimants home.

FSCO will provide the insurer with a certificate identifying the selected DAC; the certificate must be attached to the OCF-11 DAC Referral, Plan, and Summary Form. The insurer is also required to ensure the claimant or the claimant's legal representative receives a copy of the certificate.

FSCO will conduct only one search for each required DAC, except in those situations permitted by the Guideline. Non-compliance with the DAC selection process will constitute an Unfair or Deceptive Act or Practice under Regulation 7/00 of the *Insurance Act* and will be subject to prosecution.

Designated Assessment Centre Information Sheet

With this Bulletin, a Designated Assessment Centre Information Sheet is being issued to inform claimants about the DAC selection process and provides answers to commonly asked questions about the DAC system. Insurers should provide this information sheet to claimants where a DAC assessment is required.

Contact Information

Questions about this Bulletin should be directed to FSCO's Automobile Insurance Policy Unit by calling the DAC Hotline at 416-590-7137 or 1-800-668-0128, extension 7137, the fax number is (416) 590-7265. You may also contact us via e-mail at: dacselection@fsco.gov.on.ca or write to FSCO at:

Automobile Insurance Policy Unit

Financial Services Commission of Ontario

5160 Yonge Street, Box 85

North York ON M2N 6L9

ATTN: DAC Selection

Revised Accident Benefit Claims Form (OCF-22) Application for Approval of an Assessment or Examination

With this Bulletin, the revised Accident Benefit Claims Form (OCF-22) Application for Approval of an Assessment or Examination is being released. The revised form clarifies that the form is applicable to all applications for assessments or examinations for accidents that occurred on or after November 1, 1996.

Bryan P. Davies

Chief Executive Officer and

Superintendent of Financial Services

September 12, 2003

Attachments (PDF):

- Guideline on Designated Assessment Centre Selection Process
- Designated Assessment Centre Information Sheet
- Application for Approval of an Assessment or Examination (OCF-22)

To view PDF files, you will require Adobe Acrobat® Reader version 7.0. You can download this free software from Adobe's Web site.

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Financial Services Commission of Ontario
5160 Yonge Street
Toronto, ON M2N 6L9
1-800-668-0128
(416) 250-7250

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

September 2003

Guideline on Designated Assessment Centre Selection Process

Superintendent's Guideline No. 04/03

Guideline on Designated Assessment Centre Selection Process

Introduction

Regulation 313/03, which comes into effect on October 1, 2003, changes the process under section 53 of the Statutory Accident Benefits Schedule (SABS) for selecting a Designated Assessment Centre (DAC) to conduct a designated assessment. Effective October 1, 2003, the SABS no longer requires a claimant to be assessed at the DAC closest to his or her residence.

Section 53 of the SABS, as amended effective October 1, 2003, is attached to this Guideline for reference.

This Guideline defines the process by which the Superintendent will select a DAC under section 53 of the SABS.

Notification/Termination

In the event that a benefit is disputed by an insurance company, the insurance company is required to give the claimant an explanation of benefits payable, and notice of assessment, denial, reduction or termination of benefits through the provision of the following forms as appropriate:

- OCF-9 Explanation of Benefits Payable by Insurance Company
- OCF-17 Notice of Stoppage of Weekly Benefits and Request for Assessment
- OCF-20 Catastrophic Impairment Determination and Request for Assessment

These forms are also to be used by a claimant who wishes to dispute the insurance company's assessment, denial, reduction or termination of benefits and be assessed at a DAC.

Both the OCF-9 and the OCF-17 provide a general overview of the claimant's right to dispute.

Selection of a DAC by Agreement of Insurer and Claimant

As amended, section 53 of the SABS requires that if an insurer receives a notice of a claimant's request for a DAC assessment, or determines that a DAC assessment is required under the SABS, the insurer and the claimant should attempt to jointly select the DAC.

The selection is to be made no later than the second business day after the insurer or the claimant, as the case may be, receives notice from the other that a DAC assessment is required under the SABS.

If the insurer and the claimant do jointly select a DAC, the insurer will initiate the referral to the DAC and indicate on a DAC Referral, Plan, and Summary Form (OCF-11) that the DAC referral is being made jointly by the insurer and the claimant.

If the DAC is unable to begin the assessment within 14 days from the date of receiving the request for assessment, the parties will attempt to jointly select another DAC, subject to the provisions of the SABS.

Superintendent Selection of a DAC

The Superintendent will select a DAC if:

- the insurer and the claimant do not jointly select a DAC within two business days; or
- the DAC jointly selected by the parties is unable to begin an assessment within 14 days of the request for an assessment, and the parties ask the Superintendent to select another DAC.

Superintendent's Protocol for DAC Selection Process

1. In the event that the insurer and the claimant do not jointly select a DAC, the insurer must request that the Superintendent select a DAC on behalf of the parties.

2. The insurer representative is required to initiate the process via the DAC Selection Request form that can be downloaded (in WordPerfect or Word format) from the *DAC Selection* page on FSCO's website at www.fsco.gov.on.ca.

3. The insurer representative is required to complete the request and certify that the information is accurate. The insurer will attach the request to an e-mail and send it to FSCO at dacselection@fsco.gov.on.ca.

4. Within two business days, FSCO will send to the insurer representative, via e-mail, a confirmation certificate specifying the DAC selected. Each certificate will have a FSCO file number that can be used for verification.

5. The insurer must initiate a referral to the specified DAC by completing an OCF-11, printing a copy of the confirmation certificate, and attaching the copy of the certificate to the OCF-11. The insurer is also required to ensure the claimant or the claimant's legal representative receives a copy of the certificate.

6. Insurers and claimants are prohibited from using this process to make more than one request for selection of a DAC unless one of the following conditions applies:

   (a) The DAC previously selected by the Superintendent has declared a conflict of interest that is not being waived by the parties; or

   (b) The DAC previously selected by the Superintendent is unable to conduct the assessment within the required time frame; or

   (c) The claimant is being sent for an additional assessment as required by the SABS (e.g. subsequent disability assessment or multiple treatment plans), and the parties do not jointly select a DAC in the manner required by the SABS.

Section 53 of the Statutory Accident Benefits Schedule as amended effective October 1, 2003

53. (1) A designated assessment shall be conducted by a designated assessment centre selected in accordance with this section.

(1.1) A designated assessment must be conducted by a designated assessment centre that,

(a) is authorized to assess impairments of the type sustained by the insured person; and

(b) is authorized to conduct the type of designated assessment that is required.

(1.2) A designated assessment must be conducted by a designated assessment centre that is located within,

1. 30 kilometres of the insured person's residence, if,

(i) the insured person's residence is located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 30 kilometres of the insured person's residence; or

(b) 50 kilometres of the insured person's residence, if,

(i) the insured person's residence is not located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 50 kilometres of the insured person's residence.

(1.3) Subject to subsections (1.1) and (1.2), the insurer and the insured person may jointly select the designated assessment centre if the selection is made not later than the second business day after the insurer or the insured person, as the case may be, receives notice from the other that a designated assessment is required under this Regulation.

(1.4) If the insurer and the insured person do not jointly select the designated assessment centre in accordance with subsection (1.3), the Superintendent shall, subject to subsections (1.1) and (1.2), select the designated assessment centre.

(2) If the designated assessment centre is selected by the Superintendent, the designated assessment centre shall, before conducting the designated assessment, give the insurer and the insured person notice disclosing any conflict of interest that the centre has relating to the designated assessment.

(3) The designated assessment centre shall give any notice required under subsection (2) in respect of a designated assessment described in subsection 43 (11) within three business days after receipt of the request for the designated assessment.

(4) If a conflict of interest is disclosed under subsection (2),

(a) the designated assessment centre shall conduct the designated assessment if the insurer and the insured person agree; or

(b) if the insurer and the insured person do not agree, the designated assessment shall be conducted, subject to subsections (1.1), (1.2) and (2), by another designated assessment centre selected by the Superintendent.

(5) For the purposes of clause (4) (b), the insurer and the insured person shall be deemed not to agree in the case of a designated assessment described in subsection 43 (11) unless they agree by the end of the third business day after the day the insurer receives the notice under subsection (2) or the insured person receives the notice under subsection (2), whichever day is later.

[subsections (6), (7) & (8) are revoked]

(9) Except as otherwise required under subsection 43 (11), a designated assessment centre must begin a designated assessment within 14 days after receiving a request for the designated assessment.

(10) If a designated assessment centre is unable to begin a designated assessment within 14 days after receiving the request for the assessment, the insured person or the insurer may require that, subject to subsections (1.1), (1.2) and (2), the designated assessment be conducted by another designated assessment centre selected by the Superintendent.

(10.1) The Superintendent may, with the consent of the Minister, delegate in writing to any person the Superintendent's authority to select designated assessment centres under this section.

(11) For the purpose of this section, a designated assessment centre has a conflict of interest relating to a designated assessment if,

(a) the insurer, the insured person or a lawyer or other representative acting on behalf of the insurer or the insured person has a financial interest in the designated assessment centre; or

(b) the designated assessment centre, a related person, an assessor or consultant who will carry out all or part of the designated assessment or a facility owned or controlled, directly or indirectly, in whole or in part, by the centre or a related person,

(i) has provided goods or services to the person to be assessed, other than a previous designated assessment,

(ii) prepared or approved a treatment confirmation form under section 37.1, a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2 for the person to be assessed, or

(iii) is identified by a treatment confirmation form, treatment plan or an application for approval of an assessment or examination as a person who will provide goods or services to the person to be assessed.

(12) In clause (11) (b),

"related person" means, in respect of a designated assessment centre, an owner, partner or another person who has a financial interest in the designated assessment centre, but does not include a person who has a financial interest in the designated assessment centre by reason only of being a creditor who deals at arm's length with the designated assessment centre.

Financial Services Commission of Ontario
Commission des assurances de de l'Ontario

DESIGNATED ASSESSMENT CENTRE INFORMATION SHEET

THIS INFORMATION SHEET IS INTENDED FOR USE BY CLAIMANTS

WHAT CLAIMANTS NEED TO KNOW ABOUT DESIGNATED ASSESSMENT CENTRES

What is the Designated Assessment Centre (DAC) System?

DACs were set up throughout Ontario in 1994 to provide unbiased opinions about the injuries of car accident victims and the care or treatment they may need.

Each DAC must be approved by the Minister's Committee on the DAC System (DAC Committee), which appointed by the Minister of Finance and includes consumers, health care professionals, insurance company representatives and lawyers. The DAC Committee issues Guidelines to assist DACs in writing reports that are fair and based on the most up-to-date information.

There are five types of DAC assessments:

- Disability
- Medical and Rehabilitation
- Attendant Care
- Catastrophic Impairment [For accidents on or After November 1, 1996]
- Residual Earning Capacity [For accidents between January 1, 1994 and October 31, 1996]

The health care professionals at each DAC are only authorized to perform the types of assessments for which the DAC has been approved. Some DACs perform more than one type of assessment. If you and your insurer are involved in a dispute over more than one issue, you may have to attend more than one assessment. Sometimes the separate assessments can be done by one DAC at the same time.

What determines which DACs may do the assessment?

Ontario insurance law outlines which DACs may do the assessment:

- The DAC must be authorized to conduct the type of assessment that is required in your case.
- If you live within the Greater Toronto Area (the City of Toronto and the regional municipalities of Durham, Halton, Peel and York), the assessment must be conducted by a DAC located within 30 kilometres of your home.
- In all other areas of Ontario, the assessment must be conducted by a DAC located within 50 kilometres of your home.

There may be any number of DACs in your area that are able to conduct the assessment. Your insurance company will provide you with a list of DACs that meet the selection criteria.

If you wish to review the list of DACs, the full roster of DACs can be found on FSCO's website at www.fsco.gov.on.ca (Click on Insurance, then Designated Assessment Centres).

How do we jointly select a DAC?

Once the need for a DAC assessment has been identified, you and your insurer have two business days to try to agree on a DAC to conduct the assessment.

Those two business days begin to run on the day after either one of you receives notice from the other that a DAC assessment is needed.

There are no restrictions on which DAC you and your insurer agree on, other than those outlined above under *What determines which DAC may do the assessment?.*

If an agreement on a DAC is reached, it is the responsibility of your insurer to refer your file to the DAC to begin the assessment process.

What happens if we are unable to jointly select a DAC?

If you and your insurer are unable to jointly select a qualifying DAC within two business days, your insurance company must ask FSCO to select a DAC to conduct the assessment.

Under FSCO's selection process, a DAC will be selected from the roster of qualifying DACs.

The DAC selected by FSCO may not be the DAC closest to your home. Also, neither you nor your insurer will be able to ask for another selection unless the DAC selected by FSCO is not able to conduct the required assessment (ie. Conflict of interest or inability to meet required timelines).

Once FSCO has selected a DAC, you will be notified by the insurer and the insurer will then send the necessary information to the DAC to begin the assessment process.

What information should be sent to the DAC?

The **Designated Assessment Referral Plan and Summary Form (OCF-11)** is to be completed by the insurer. The OCF-11 requires the insurer to indicate the type of assessment to be conducted and specifics regarding the issues in dispute.

All of the information forwarded by the insurer to the DAC will form part of the assessment. The insurer is required to send copies of the OCF-11A to the DAC and to you.

When you receive your copy of the OCF-11, you should review the list of documents sent to the DAC. It is your responsibility to provide the DAC with any other documents, such as recent test results, which may be useful in completing the assessment.

With more complete information, the DAC will be able to conduct a better assessment and help resolve the issue in dispute.

What if the DAC requests more information?

There may be cases where, in the opinion of the DAC, important information is missing. The DAC may then ask you or your insurer to provide the missing information, and advise that the assessment could be delayed depending on what information is missing.

If the DAC can get this missing information more quickly on its own, the DAC may gather the information directly, provided that it does so with your permission.

What happens after you have been assessed at a DAC?

After the DAC has looked at the case, the DAC will write a report explaining *clearly* how the assessment was conducted, the results of the assessment, and what the DAC concludes about your case *and the reasons* for its opinion.

A final, written report will be produced at the end of an assessment. No final written report can be produced if parts of the assessment have yet to be completed. The DAC will provide you and your insurer with written reasons why the assessment was not completed, and confirm that no final

report will be produced until the entire assessment is completed.

Please note that the only time a DAC is permitted to issue an addition to a DAC report is to clarify the DAC findings, to correct an error in the original DAC report, or to deal with something missing in the DAC report.

If new information emerges and the parties agree that the review of the *new* material may change the DAC's opinion, then a new DAC assessment should be arranged. Neither party should request an "updated" report from the DAC.

Where the parties disagree with either the report of the DAC or the impact of any new information on the original DAC findings, either party may choose to apply for mediation with the Dispute Resolution Services Branch of the Financial Services Commission of Ontario.

What do you do if you have a complaint about a DAC?

The DAC Committee has established a process to deal with complaints regarding DACs which fail to conduct assessments as set out in the procedures and guidelines issued by the DAC Committee.

The DAC Committee cannot review complaints which fall outside its control, including complaints relating to the business practices of an insurer, the professional conduct of a health care provider or complaints concerning the conclusions in a DAC Report.

How can I get more information?

If you have any questions regarding the DAC System and the assessment process, you may direct your questions to:

The Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street, Box 85
Toronto ON M2N 6L9

You may also call the DAC hotline at 416-590-7137 or 1-800-668-0128, extension 7137.

If you want copies of any published DAC material, including an up-to-date roster of DACs, please visit FSCO's website at **www.fsco.gov.on.ca** (Click on Insurance, then Designated Assessment Centres).

Application for Approval of an Assessment or Examination (OCF-22)

Use this form for accidents that occur on or after November 1, 1996

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

To the Applicant:

Use this form to request prior approval for payment of an assessment or examination fee for which prior approval is required.

Please provide all information requested.

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

To the Health Professional/Facility:

Consent: It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted is authorized by a consent form. Health professionals/facilities should use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form.

A submission for insurer approval/payment of an expense for an assessment or examination may be made either with this form or a Treatment Plan (OCF-18) form.

Part 1 Applicant Information

To be completed by the applicant

Date Of Birth (YYYYMMDD)	Gender ❑ Male ❑ Female	Telephone Number Extension
Last Name		
First Name	Middle Name	
Address		
City	Province	Postal Code

Part 2 Insurance Company Information

To be completed by the applicant

Company Name	City or Town of Branch Office (if applicable)	
Adjuster Last Name	Adjuster First Name	
Adjuster Telephone Extension	Adjuster Fax	
Name of policy holder same as: ❑ Applicant OR	Policy Holder Last Name	Policy Holder First Name

Part 3 Signature of Regulated Health Professional

Name of Regulated Health Professional		College Registration Number
Facility Name (if applicable)		AISI Facility Number (if applicable)
Address		
City	Province	Postal Code
Telephone Number Extension		Fax Number
Email Address		

You are a:

- ❑ Chiropractor
- ❑ Dentist
- ❑ Massage Therapist
- ❑ Nurse Practitioner
- ❑ Occupational Therapist
- ❑ Optometrist
- ❑ Physician
- ❑ Physiotherapist
- ❑ Psychologist
- ❑ Speech-Language Pathologist
- ❑ Other _____

❑ I wish to declare that I have no conflicts of interest relating to this form and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form, ***or***

❑ I am declaring the following conflicts of interest relating to this Application:

I certify that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.

Name of Regulated Health Professional (please print)	Signature of Regulated Health Professional	Date (YYYYMMDD)

Part 4 Nature of Assessment or Examination

Payment for all assessments and examinations is dependent upon approval by the insurer or, if disputed, by a DAC except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please ✓ the appropriate box in the chart below to indicate what situation applies to this application.

PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING :

- ❑ An assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;
- ❑ not more than three assessments or examinations if:
  - the insured person has not received treatment under a *Pre-approved Framework Guideline*,
  - the cost of each assessment or examination does not exceed $180.00, and
  - not more than one assessment or examination is done by the same person;
- ❑ not more than one assessment or examination if:
  - the insured person has received treatment under a *Pre-approved Framework Guideline*,
  - the cost of the assessment or examination does not exceed $180.00, and
  - the person conducting the assessment or examination did not provide goods or services under a Pre-approved *Framework Guideline* in respect of the same accident;
- ❑ an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR:

- ❑ all other assessments or examinations to complete Treatment Plans, not outlined above.

ASSESSMENTS OR EXAMINATIONS TO COMPLETE DISABILITY CERTIFICATES:

- ❑ Prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment for the certificate does not exceed $180.00;
- ❑ prior approval is required for assessments to complete disability certificates that exceed $180.00;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

ASSESSMENTS OR EXAMINATIONS TO PREPARE A FORM 1:

- ❑ Prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1, but not an assessment or examination relating to an impairment that comes within a *Pre-approved Framework Guideline* unless the *Pre-approved Framework Guideline* expressly states that the prior approval of the insurer is not required for the assessment or examination;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

ASSESSMENTS OR EXAMINATIONS TO DETERMINE CATASTROPHIC IMPAIRMENT:

- ❑ Prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is hospitalized or in a long-term care facility at the time of the assessment or examination.
- ❑ prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL:

- ❑ All other assessments not outlined above require prior approval.

Part 5 Provisional Clinical Information

a) Clinical Information:

i) Provide a brief description of the present complaints.

ii) Has the applicant already been provided treatment under your care? ❑ No ❑ Yes

b) Assessment Information:

i) Describe the details of the assessment requested and the rationale for it.

- If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment.
- For multi-disciplinary assessments, include the detail and rationale for each component of the assessment.

iii) After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant?
❑ No ❑ Yes

If yes, provide date if possible (YYYYMMDD) _____/_____/____

Applicant Name:		OCF-22 - FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 6 Health Providers

Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A						
B						
C						
D						
E						
F						

Part 7 Proposed Goods and Services

This Assessment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility.

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimated		
					Quantity	†Measure	Total Cost
1							
2							
3							
4							
5							
6							
7							
8							

Note †: Refer to the User Manual coding guidelines posted at www.autoinsurancereforms.on.ca. Attribute codes are used to further qualify the service codes and are described in the manual.

Note ✦: Payment by auto insurer is secondary to available collateral benefits.

Sub-Total:	
✦MOH:	
✦Other Insurer 1 + 2:	
GST (if applicable):	
PST (if applicable):	
Auto Insurer Total:	

Part 8 Signature of Applicant

(Optional)
If not completed, the Health Professional in Part 3 assumes responsibility for obtaining applicant's consent

I have reviewed and confirm that the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer, or if disputed by the insurer, a Designated Assessment Centre. In the event that my insurer disputes the application, I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.
I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.
Subject to the Statutory Accident Benefits Schedule, in those instances where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

Part 9 Signature of Insurer

❑ I waive the requirement for the applicant's signature on a OCF 18 Treatment Plan.

I have reviewed this form and based upon the information provided, I

❑ Approve ❑ Partially approve (explanation to follow or attached) ❑ Do not approve (explanation to follow or attached)

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 2 business days of receiving the completed form for proposed assessments of $180.00 or less, and within 5 business days when the cost of the proposed assessment is over $180.00:

1. Give the health professional and the applicant notice of the decision.
2. If disputing the application refer the dispute to a Designated Assessment Centre.

Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.

Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.