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Guideline and Changes to Certain Accident Benefit Claim Forms

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Bulletin

No. A-08/07

Property & Casualty

– Auto

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Health Claims for Auto Insurance Guideline and Changes to Certain Accident Benefit Claim Forms

To the attention of all insurance companies licensed to transact automobile insurance in Ontario and all**health care providers**

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is releasing the Health Claims for Auto

Insurance Guideline (the Guideline) to replace the Health Claims for Auto Insurance Rollout Guideline issued in April 2007. Also being revised are certain accident benefit forms to show what fields are mandatory.

Guideline

This Guideline is issued pursuant to section 268.3 (1) of the *Insurance Act* for the purposes of setting out the requirements for delivery of certain documents under sections 44.1(1) and 68(3.2) of the *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996* (SABS) as amended by Regulation 533/46. The Guideline mandates the transmission of certain accident benefit claims forms between health care providers and insurers by way of a Central Processing Agency (CPA). The CPA is the agent designated to receive accident benefit claim forms on behalf of insurers. The Guideline names Health Claims for Auto Insurance Processing (HCAI), an Ontario not-for-profit corporation, as the CPA.

As of February 1, 2008, all OCF 18, 21, 22 and 23 forms can no longer be delivered by a health care provider directly to an insurer, and must instead be delivered to HCAI for processing. As indicated in the Guideline, the system is designed to enable health care providers to enroll in one of two systems for submission of these forms: either electronically, or in paper format. Paper submission of documents will need to be made to HCAI's data entry centre (DEC) and becomes available as of January 7, 2008. In addition to receiving forms, HCAI will also confirm that forms are completed and make this information available to the specific insurers to whom they are addressed. HCAI also enables insurers to communicate claims approval and payment decisions to health care providers who submit forms electronically.

The Guideline also:

- sets out specific accident benefit claim forms that are subject to this Guideline and that must be delivered to HCAI;
- describes how to deliver documents to HCAI and its DEC;
- includes rules governing attachments and when documents are considered received by HCAI and its DEC;
- includes rules dealing with the deemed receipt of documents;
- includes coding information required to complete specified forms and documents; and
- provides other technical details regarding HCAI's operation.

HCAI Participant List

The HCAI Participant List will no longer be maintained by FSCO after February 1, 2008 when the system becomes mandatory for all insurers, health care providers and facilities. Insurers are requested to be proactive in the transition period, and are encouraged to process forms as normal if received directly from health care providers on or before February 7, 2008. Insurers are also requested to contact and inform health care providers about the HCAI system if the applicable forms are sent directly to them.

Paper Submissions

HCAI's DEC has been established in order to allow for the submission of paper forms to a participating insurer by a participating health care provider. Starting January 7, 2008, the paper versions of the forms may be delivered to HCAI's DEC. Please note that a health care provider must choose which system it wants to utilize with HCAI, as it

cannot be enrolled in both the electronic and paper submission systems simultaneously.

As indicated in the attached Guideline, any attachments to a form must be delivered directly to the insurer and not sent to HCAI's DEC. Any attachments sent to the DEC will be deemed to have not been received by the insurer, and will not be returned, but will be destroyed.

Documents submitted to HCAI's DEC must be properly completed in accordance with the directions set out in the revised OCF forms, and the validation rules that are attached to the Guideline. HCAI's DEC will notify providers of forms that are incomplete, or incorrectly completed within two business days of receipt by the DEC. Providers are encouraged to correct the errors identified in the DEC error report and resubmit the form as quickly as possible to the DEC.

Enrolment in HCAI

Insurers and providers must complete the enrolment process for HCAI before using the system. Any forms delivered to HCAI prior to enrollment will not be processed.

Please note that there are separate enrolment processes for each mode of transmission (electric or paper). This means that providers who wish to switch from one mode to the other must notify HCAI of the fact and will be required to complete the appropriate enrolment process.

Additional HCAI Information

Additional information on the HCAI system and how to enroll with the CPA electronically or for paper submissions through the DEC can be found at: www.hcaiinfo.ca.

Effective Dates for the Guideline

This Guideline applies to all insurers, health providers and facilities in respect of documents specified in the Guideline that are delivered on or after February 1, 2008, regardless of the date of the motor vehicle accident.

In regards to the submission of paper documents, this Guideline applies to all participating insurers and health care providers who have volunteered to be a part of the rollout phase and registered for HCAI's DEC effective January 7,

2008. For all other parties the effective date is February 1, 2008.

Revised Accident Benefit Claim Forms

To assist in facilitating paper submissions to HCAI's DEC, Ontario Claim Forms (OCF) 18, 21, 22 and 23 have been revised to highlight which fields must be completed. There are four categories of fields on the forms. A field without an asterisk indicates that it is mandatory and must be completed; a field with one asterisk (*) indicates that a field is required if known; a field with two asterisks (**) indicates that at least one of the two adjacent fields must be completed; and, a field with three asterisks (***) indicates that a field is optional.

Effective Date of Revised Forms

Health care providers can use the revised versions of these forms effective January 7, 2008. Health care providers can also continue to use their existing stock of OCF 18, 21, 22 and 23 forms when submitted to the DEC provided that all fields are properly completed as highlighted in these revisions.

HCAI's DEC can continue to accept the older versions of these forms up to and including July 31, 2008. Effective August 1, 2008, the revised versions of these forms will be required for use for all paper submissions to HCAI's DEC.

Publication

The Guideline will be published in an upcoming edition of *The Ontario Gazette*. The Guideline is also posted on the FSCO website at www.fSCO.gov.on.ca.

Bob Christie

Chief Executive Officer and

Superintendent of Financial Services

December 21, 2007

Attachments:

- [Health Claims for Auto Insurance Guideline](#)

- Revised OCF [18](#), [21](#), [22](#) and [23](#)



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Financial Services
Commission
of Ontario

Commission des
services financiers
de l'Ontario

December 2007

Health Claims for Auto Insurance Guideline

Superintendent's Guideline No. 07/07

Health Claims for Auto Insurance Guideline

Introduction

This Guideline replaces the Health Claims for Auto Insurance Rollout Guideline No. 01/07 issued in April 2007, and is issued pursuant to s. 268.3 (1) of the *Insurance Act* for the purposes of ss. 44.1 (1) and 68 (3.2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) as amended by Regulation 533/06.

The SABS amendments change the way that some SABS claim documents are to be sent to insurers in some circumstances. A document to which this Guideline applies and that previously would have been sent directly to an insurer to whom this Guideline applies is instead to be sent to a Central Processing Agency (CPA) established by the insurance industry to receive such documents on behalf of insurers. This Guideline describes:

- which insurers, health care facilities (“facilities”) and health care providers (“providers”) are subject to the Guideline and in what circumstances,
- what documents are to be delivered to the CPA and in what circumstances,
- how such documents may be delivered to the CPA, and
- how insurers are to provide information to the CPA.

This Guideline applies to documents specified in this Guideline that are delivered on or after April 2, 2007, regardless of the date of the accident to which they relate.

Insurers and Providers That Are Subject To This Guideline

- **On or after April 2, 2007 but before February 1, 2008:**

The Financial Services Commission of Ontario maintains and updates from time to time a list of identified insurers and facilities/providers (or specified branch offices thereof) participating in the Health Claims for Auto Insurance (HCAI) (the “HCAI Participant List”) and the dates on which their participation begins. Please see Appendix 1 for details of how to obtain copies of the HCAI Participant List in effect at any particular time.

For the purposes of this Guideline:

- each specified branch office of an identified insurer is a Participating Insurer, and

- each specified branch office of an identified facility, and each provider operating in a specified branch office of an identified facility, is a Participating Provider.

This Guideline applies only to transactions between a Participating Provider and a Participating Insurer in respect of any claim for SABS benefits under a motor vehicle liability policy issued in Ontario.

- **On and after February 1, 2008:**

This Guideline applies to all insurers licensed in Ontario in respect of all claims for SABS benefits under any motor vehicle liability policy issued in Ontario. This Guideline also applies to all health care facilities and health care providers that practice in Ontario and mail or otherwise deliver, on or after February 1, 2008, any document to which this Guideline applies. For the purposes of this Guideline, each such insurer is a Participating Insurer, and each such facility and provider is a Participating Provider.

This Guideline does not apply to:

- any reinsurer in respect of claims under a contract of reinsurance,
- any insurer in respect of which a winding-up order has been made under the *Winding-up and Restructuring Act* (Canada), or
- the Motor Vehicle Accident Claims Fund.

Designation of Central Processing Agency – SABS s. 68 (3.2)

Health Claims for Auto Insurance Processing is the CPA for the purposes of this Guideline and s. 68 (3.2) of the SABS. Health Claims for Auto Insurance Processing is a not-for-profit Ontario corporation established and funded by the insurance industry and operated by a board of directors that includes representatives of the insurance industry and health care communities.

The primary role of the CPA is to act as the agent of insurers to receive specified documents on their behalf, to confirm that the documents are duly completed and contain all of the information required to be included in them, and then to make the documents available for access by the insurers to whom they are addressed. The CPA also acts as an intermediary for the purpose of enabling insurers to communicate information such as claims approval and payment decisions electronically to those health care goods and services providers who wish to receive such communications electronically through the CPA.

The CPA is also expected to be a primary source of the information that automobile insurers will be required under s. 101.1 of the *Insurance Act* to provide to the Superintendent of Financial Services concerning claims for goods

and services for which automobile insurers are liable under contracts of automobile insurance.

Invoices For Goods And Services That Are Subject To This Guideline – SABS s. 44.1

Any invoice for goods or services specified in Appendix 2 of this Guideline for the purposes of s. 44.1 of the SABS must be in the form (the Auto Insurance Standard Invoice) approved by the Superintendent of Financial Services in accordance with s. 69 of the SABS.

This requirement applies only if:

- all of the goods or services referred to in the invoice are provided in Ontario by the Participating Provider,
- the invoice is not submitted by the claimant,
- the invoice is submitted by a Participating Provider and is payable to the Participating Provider, and
- payment of the invoice is claimed against a Participating Insurer with respect to a transaction with a Participating Provider.

Where this requirement applies, s. 44.1 (1) of the SABS prohibits a Participating Insurer from paying any invoice that is not in the approved form, does not include all of the information required by the approved form, or is not sent to the CPA as required by this Guideline.

Participating Providers are to invoice Participating Insurers for goods or services specified in Appendix 2 separately from goods or services not specified in Appendix 2. Similarly, Participating Providers are to invoice Participating Insurers for goods or services provided in Ontario separately from goods and services not provided in Ontario.

Documents That Must Be Delivered To The CPA

The following documents are specified for the purpose of s. 68 (3.2) of the SABS. Each such document must be delivered to the CPA (not directly to the insurer to whom it is addressed) in accordance with this Guideline if delivered by a Participating Provider to a Participating Insurer:

- | | |
|--------|--|
| OCF-18 | Treatment Plan - SABS s. 38 |
| OCF-21 | Auto Insurance Standard Invoice - SABS s. 44.1 – but only if this Guideline requires the use of this form for the particular goods or services being billed* |

OCF-22	Application for Approval of an Assessment or Examination - SABS s. 38.2
OCF-23/198	Pre-approved Framework Treatment Confirmation Form - SABS s. 37.1

Please note that (with one exception – see * below) a document that this Guideline does not require to be delivered to the CPA must be delivered directly to the insurer using one of the delivery methods provided for in s. 68 (2) of the SABS.

* An OCF-21 submitted to invoice an insurer only for the completion of a Disability Certificate (OCF-3) may be delivered either to the CPA in accordance with this Guideline, or directly to the insurer, at the option of the Participating Provider.

Section 68 (3.2) of the SABS provides that a document to which this Guideline applies is deemed not to have been delivered to an insurer unless it is delivered to the CPA as required by this Guideline. If such a document is delivered directly to an insurer instead of to the CPA despite the requirements of this Guideline, the insurer is under no obligation to respond to it as the document will be deemed not to have been received by the insurer.

How To Deliver Documents To The Central Processing Agency

A document that is required by this Guideline to be delivered to the CPA shall be delivered in either of the following ways:

- (1) Electronic Submission, or
- (2) Paper Submission

(1) Electronic Submission

The document may be delivered to the CPA in electronic form in a manner that results in it being capable of being retrieved and accessed by the CPA.

Participating Providers are authorized to deliver documents to the CPA electronically as described above, and to access information electronically from the CPA, once they have completed the appropriate enrolment process (see “**Enrolment Of Users And Providers**” below).

A Participating Provider may elect to enroll for either electronic submission or paper submission, but not both at the same time.

As noted below under “**Rules Governing Date of Receipt of Documents By Insurers**”, any document delivered to the CPA by a Participating Provider that has not completed this enrolment process will be deemed not to have been received by the insurer, and will not be processed.

(2) Paper Submission

The CPA has established a data entry centre that is equipped to receive paper documents delivered by a Participating Provider in accordance with this Guideline on and after January 7, 2008.

On and after January 7, 2008, documents may be delivered to the CPA in paper form, by mail, fax or personal delivery in accordance with ss. 68 (2) (a), (b), (c) or (d) of the SABS, if addressed to the CPA's data entry centre as follows:

HCAI Processing – Data Entry Centre
P.O. Box 254
Orangeville, ON L9W 3Z5
Fax number: (866) 346-6744

Participating Providers are authorized to deliver documents in paper form as described above once they have completed the appropriate enrolment process (see “**Enrolment Of Users And Providers**” below).

A Participating Provider may elect to enroll for either electronic submission or paper submission, but not both at the same time.

As noted below under “**Rules Governing Date of Receipt of Documents By Insurers**”, any document delivered to the CPA's data entry centre by a Participating Provider that has not completed this enrolment process, and any document delivered by any Participating Provider before January 7, 2008, will be deemed not to have been received by the insurer, and will not be processed.

Attachments to Documents That Are Subject To This Guideline

For the purposes of this Guideline, “attachments” means any material (e.g., additional pages, reports, test results) submitted in support of a document to which this Guideline applies.

If a Participating Provider determines that it is necessary to send one or more attachments rather than including in the document itself all information that the sender determines to be desirable or necessary to accomplish its purpose, the following special rules apply:

1. The Participating Provider must specify, in the field provided in the document for that purpose, how many attachments are being delivered.
2. The document itself (but not the attachments) must still be delivered to the CPA (if in electronic format) or the CPA's data entry centre (if in paper form) as described above.
3. The attachments are not to be delivered to the CPA (or the CPA's data entry centre), but instead must be delivered directly to the insurer by one of the delivery methods described in s. 68 (2) of the SABS. Although it is

preferable that all attachments be delivered to the insurer at the same time, it is not mandatory to do so.

Please note that any attachment delivered to the CPA or the CPA's data entry centre will be deemed not to have been received by the insurer, and will not be returned, but will be destroyed.

4. The attachments are not to be sent to the insurer before the document is sent to the CPA.
5. Each attachment must be identified with the claimant's name, either of claim number or policy number, and date of accident, and with the document type (i.e., OCF-18, OCF-21, OCF-22 or OCF-23/198) to which the attachment relates, to enable the insurer to identify the document for which the attachment is intended.

Rules Governing Date of Receipt of Documents By Insurers

Section 68 of the SABS sets out the rules that determine when a document delivered to the CPA as required by this Guideline is deemed to be received by the insurer to whom it is addressed. Briefly summarized, those rules provide:

1. **Document with no attachments** – is deemed to be received by the insurer to whom it is addressed when the document has been delivered to the CPA in a manner specified in this Guideline, and the CPA has determined that the document is duly completed and contains all information required by the SABS to be included in it.
2. **Document with attachments** – is deemed to be received by the insurer to whom it is addressed when:
 - (a) the document (exclusive of attachments) has been delivered to the CPA in a manner specified in this Guideline, and the CPA has determined that the document is duly completed and contains all information required by the SABS to be included in it; and
 - (b) all of the attachments have been received by the insurer.

The SABS provides (s. 68 (7)) that a document delivered to the CPA by fax, personal delivery or by electronic submission later than 5:00 p.m. Eastern time is deemed to have been delivered to the CPA on the following business day.

The SABS also provides (s. 68 (3.5)) that the CPA will be deemed to have determined, on the day a document was delivered to it in a manner specified in this Guideline, that the document is duly completed and contains all information required by the SABS to be included in it unless the CPA notifies the sender to the contrary in a manner specified in this Guideline.

For the purposes of s. 68 (3.5), the manner in which the CPA is to notify the sender is by one of the delivery methods provided for in s. 68 (2) of the SABS. The CPA may also deliver the notification verbally (for example by telephone call, or by telephone message) provided written confirmation is given as soon as practicable afterwards by one of the delivery methods provided for in s. 68 (2) of the SABS.

As previously noted, the SABS further provides (s. 68 (3.2)) that a document to which this Guideline applies is deemed not to have been delivered to an insurer unless it is delivered as required by this Guideline. Any document delivered to the CPA (either directly or through its data entry centre) by a Participating Provider that has not completed the enrolment process, and any paper document delivered by any Participating Provider to the CPA's data entry centre before January 7, 2008, is not delivered as required by this Guideline and therefore shall be deemed not to have been delivered to an insurer.

Completion of Documents

A document to which this Guideline applies will be deemed not to have been completed and not to contain all the information required by the SABS to be included in it unless all fields (other than those that are optional in the circumstances indicated on the form as approved by the Superintendent of Financial Services) are completed as required by this Guideline.

The information in any completed field must comply with the validation rules set out in Appendix 3 of this Guideline.

Where the form specifies the format in which certain information (e.g., a date) is to be provided, the information must be provided in that format.

If the document is delivered in paper form, all completed fields must be legible.

All attachments must be legible.

Codes To Be Used In Submitting Information

The following information shall be provided utilizing the codes specified below:

- To describe injuries and *sequelae*, codes listed in the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) which is maintained by the Canadian Institute for Health Information and available through www.cihi.ca. An abridgment of the ICD-10-CA list of codes, developed to assist stakeholders in the Ontario automobile insurance system, is available at www.hcaiinfo.ca.
- To describe health interventions, codes listed in the Canadian Classification of Health Interventions (CCI) which is maintained by the Canadian Institute for Health Information and available through

www.cihi.ca. An abridgment of the CCI list of codes, developed to assist stakeholders in the Ontario automobile insurance system, is available at www.hcaiinfo.ca.

- To describe provider types, the list of Provider Type Codes available at www.hcaiinfo.ca.
- To describe payment categories under a Pre-approved Framework, the list of Pre-approved Framework Reimbursement Codes available at www.hcaiinfo.ca.
- To describe items billed to automobile insurers by providers that are not covered by the CCI, the list of Goods, Administration, and Other Codes available at www.hcaiinfo.ca.
- To describe unit measures and for converting minutes to hours, the list of Unit Measure Codes and the Minutes to Hour Conversion Table available at www.hcaiinfo.ca.

The information at www.hcaiinfo.ca is maintained by Insurance Bureau of Canada in cooperation with the professional associations referred to at <http://www.hcaiinfo.ca/links.asp>.

Requirements For Insurers

Where the SABS requires a Participating Insurer to provide information to the CPA, such information shall be delivered to the CPA in electronic form in a manner that results in it being capable of being retrieved and accessed by the CPA.

The information referred to in s. 44.1 (3) of the SABS concerning the processing of an invoice must be provided to the CPA within five business days after the invoice has been processed by the Participating Insurer.

The information referred to in s. 68 (3.8) of the SABS concerning any other document to which this Guideline applies must be provided to the CPA within five business days after the document has been processed by the Participating Insurer.

The information referred to in s. 68 (3.9) of the SABS concerning receipt of attachments must be provided to the CPA within five business days after the last attachment has been received by the Participating Insurer.

The deadlines referred to above are independent of, and not to be confused with, the deadlines within which an insurer is to process and respond to a document as set out in the SABS.

A Participating Insurer that has completed the enrolment process as an Insurer (see “Enrolment of Users And Providers” below) is authorized to deliver

information to the CPA electronically and to access from the CPA information that has been delivered to the CPA by a Participating Provider.

Enrolment Of Users And Providers

Before submitting information to, or receiving information from, the CPA, a provider, facility or insurer that is a Participating Provider or Participating Insurer shall enroll with the CPA and agree to its user terms and conditions. As noted above, providers and facilities may elect to enroll for either paper submission or electronic submission, but not both at the same time. The user terms and conditions may include commercially reasonable provisions to address responsibilities including confidentiality, security, liability, access, and data integrity.

Temporary Suspensions Of This Guideline

In the event that the CPA becomes unable (e.g., by reason of temporary technical issues) to properly carry out its obligations to providers, facilities or insurers, the Superintendent of Financial Services may temporarily suspend the operation of this Guideline.

The Financial Services Commission of Ontario will post notice of any suspension and subsequent resumption of operation of this Guideline on its website (www.fSCO.gov.on.ca).

During the period of any such suspension, the requirements of this Guideline do not apply and documents are instead to be delivered directly to insurers using one of the standard delivery methods provided for in s. 68 (2) of the SABS.

Appendix 1

HCAI Participant List

Copies of the HCAI Participant List in effect from time to time until February 1, 2008 may be obtained at <http://www.fSCO.gov.on.ca/english/insurance/auto/hcai.asp>. Alternatively, printed copies may be obtained by contacting the Financial Services Commission of Ontario at 1-800-668-0128 extension 7123.

Appendix 2

Invoices For Goods And Services That Are Subject To This Guideline – SABS s. 44.1

SABS Section	Type of Service/Goods	Specified for the purposes of section 44.1	Not specified for the purposes of section 44.1
	Medical Benefits		
14(2)(a)	Medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services	Medical, nursing, audiometric and speech-language pathology services	Surgical, dental, optometric, hospital and ambulance services
14 (2)(b)	Chiropractic, psychological, occupational therapy and physiotherapy services	✓	
14(2)(c)	Medication		✓
14(2)(d)	Prescription eyewear		✓
14(2)(e)	Dentures and other dental devices		✓
14(2)(f)	Hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices	Supplies provided to the patient by health care providers	Supplies purchased by the patient
14(2)(g)	Transportation of the insured person to and from treatment sessions, including transportation for an aide or attendant		✓
14(2)(h)	Other goods and services of a medical nature	✓	
	Rehabilitation Benefits		
15(5)(a)	Life skills training	✓	
15(5)(b)	Family counseling	✓	
15(5)(c)	Social rehabilitation counseling	✓	
15(5)(d)	Financial counseling		✓
15(5)(e)	Employment counseling		✓
15(5)(f)	Vocational assessments	✓	
15(5)(g)	Vocational or academic training		✓

SABS Section	Type of Service/Goods	Specified for the purposes of section 44.1	Not specified for the purposes of section 44.1
15(5)(h)	Workplace modification and workplace devices including communication aids		✓
15(5)(i)	Home modifications and home devices including communication aids, or a new home instead of home modifications		✓
15(5)(j)	Vehicle modifications or a new vehicle instead of modifying an existing vehicle		✓
15(5)(k)	Transportation for the insured person to and from counseling sessions, training sessions and assessments, including transportation for an aide or attendant		✓
15(5)(l)	Other goods and services other than case management		✓
16	Attendant care services	Provided by health care providers and other professional care providers	Provided by family, neighbours and other non-professional care providers
17	Case manager services	✓	
	Examinations, Completion of Reports/Certificates, etc.		
24	Disability Certificate (OCF-3)		✓
24	Treatment Plan (OCF-18)	✓	
24	Application for Determination of Catastrophic Impairment (OCF-19)	✓	
24	Assessment of Attendant Care Needs (Form 1)	✓	
24.1	Consultations	✓	
32.1 & 42	Insurer Examinations	✓	
42.1	Examinations and reports per section 42.1 of SABS	✓	

Appendix 3

Validation Rules

Item #	Data Field	Description	Validation #
OCF-18 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI, except the health practitioner in Part 5 of the OCF-18.	PM-CSR28
6	Profession	Health practitioner's profession must be one of the practitioner professions listed in the SABS.	PM-18R9
7	Date of Signature	Date of the signature of the Health Practitioner must be equal to or after the date of accident.	PM-18R7
8	Profession	Regulated Health Professional profession must be one of the regulated health professions listed on the form or named as 'other' and signatory must be associated with the submitting facility.	PM-18R10
9	Date of Signature	Date of the signature of the Regulated Health Professional or Social worker must be equal to or after the date of accident.	PM-18R6
10	Injury Code	Document must have at least one injury.	PM-CSR14
11	Line Item	There must be at least one goods and service line item. A line item can be a treatment session.	PM-18R5
12	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
13	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
14	Measure	If section code is S, measure must be SN.	N/A
15	Measure	If section code is G, measure must be GD.	N/A
16	Measure	If intervention code is TT, measure must be HR.	N/A
17	Measure	If intervention code is KM, measure must be KM.	N/A
18	Count	The projected count for each goods and services line item must be greater than 0.	PM-18R2
19	Total Cost	The projected total cost for each goods and services line item must be • greater than 0 • and must be equal to cost times projected total count	PM-18R1
20	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10

Item #	Data Field	Description	Validation #
21	GST	Total GST must be greater than or equal to 0.	PM-CSR11
22	PST	Total PST must be greater than or equal to 0.	PM-CSR12
23	Insurer total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	PM-CSR13
24	Duration of Treatment	Estimated duration of the treatment plan (in weeks) must be greater than 0.	PM-18R3
25	Date of applicant's signature	Date of an applicant's signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-22 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Profession	Regulated Health Professional's profession must be one of the regulated health professions listed in the form or named as 'other' and signatory must be associated with the submitting facility.	PM-22R5
7	Date of signature	Date of the signature of the Regulated Health Professional or Social Worker must be equal to or after the date of accident.	PM-22R4
8	Nature of Assessment or Examination	One box must be selected.	N/A
9	Date of prior assessment	If the date of prior assessment is completed, it must be after or equal to the applicant's date of birth	PM-22R1
10	Line item	There must be at least one goods and service line item.	PM-22R3
11	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
12	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
13	Measure	If section code is S, measure must be SN.	N/A
14	Measure	If section code is G, measure must be GD.	N/A
15	Measure	If intervention code is TT, measure must be HR.	N/A
16	Measure	If intervention code is KM, measure must be KM.	N/A

Item #	Data Field	Description	Validation #
17	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10
18	GST	Total GST must be greater than or equal to 0.	PM-CSR11
19	PST	Total PST must be greater than or equal to 0.	PM-CSR12
20	Insurer total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	PM-CSR13
21	Date of applicant's signature	Date of an applicant's signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-23 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Injury Code	Document must have at least one injury.	PM-CSR14
7	Profession	Regulated Health Practitioner's profession must be one of the health practitioner professions listed in the SABS.	PM-23R16
8	Date of signature	Date of the signature of the Health Practitioner must be equal to or after the date of accident.	PM-23R10
9	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
10	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
11	Measure	If section code is S, measure must be SN.	N/A
12	Measure	If section code is G, measure must be GD.	N/A
13	Measure	If intervention code is TT, measure must be HR.	N/A
14	Measure	If intervention code is KM, measure must be KM.	N/A
15	Subtotal	Subtotal of Part 9 in the document must be equal to the sum of all the line items in Part 9.	PM-CSR
16	Subtotal	Subtotal of Part 11 in the document must be equal to the sum of all the line items in Part 11.	PM-CSR
17	Total	Total of the document must be equal to the sum of the Part 9 sub-total and Part 11sub-total.	
18	Fee	Total PAF Fee must be greater than 0	PM-23R24

Item #	Data Field	Description	Validation #
19	Date of applicant's signature	Date of an applicant's signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-21A Submission Rules - apply to DEC only			
1	Plan Number	The Data Entry Centre will not accept an OCF-21A if a Treatment Plan (OCF-18) or an Application for Approval of an Assessment or Examination (OCF-22) has not been received by the DEC previously. In this case, an OCF-21B must be submitted	BR-DEC-00
2	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
3	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
4	Date of birth	Date of birth of an applicant must be equal to or prior to date of accident.	PM-CSR4
5	Date of birth	Applicant cannot be older than 120.	PM-CSR6
6	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
7	Injury Code	Document must have at least one injury.	PM-CSR14
8	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice unless the facility chooses not to "lock payable" when registering on HCAI. If this is the case, someone other than the facility can be paid.	IMBR-CS6
9	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident.	IMBR-CS42
10	Invoice	An invoice that is created from a plan can only be associated with that plan. An invoice for goods and services from more than one plan must be created from scratch.	IMBR-CS22
11	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
12	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
13	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
14	Subtotal	Subtotal of the document must be • equal to the sum of all the line items, plus • equal to the sum of GST and PST shown on each line item	PM-CSR10

Item #	Data Field	Description	Validation #
15	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	IMBR-CR1
OCF-21B Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Injury Code	Document must have at least one injury.	PM-CSR14
7	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice unless the facility chooses not to "lock payable" when registering on HCAI. If this is the case, someone other than the facility can be paid.	IMBR-CS6
8	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident.	IMBR-CS42
9	Invoice	An invoice that is created from a plan can only be associated with that plan. An invoice for goods and services from more than one plan must be created from scratch.	IMBR-CS22
10	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
11	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
12	Measure	If section code is S, measure must be SN.	N/A
13	Measure	If section code is G, measure must be GD.	N/A
14	Measure	If intervention code is TT, measure must be HR.	N/A
15	Measure	If intervention code is KM, measure must be KM.	N/A
16	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
17	Quantity	Quantity of a rendered Good or Service must be greater than 0.	IMBR-CS9

Item #	Data Field	Description	Validation #
18	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
19	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
20	Subtotal	Subtotal of the document must be • equal to the sum of all the line items, plus • equal to the sum of GST and PST shown on each line item	PM-CSR10
21	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	IMBR-CR1
OCF-21C Submission Rules			
1	Policy/Claim Number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice unless the facility chooses not to "lock payable" when registering on HCAI. If this is the case, someone other than the facility can be paid.	IMBR-CS6
7	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident	IMBR-CS42
8	Injury Code	Document must have at least one injury	PM-CSR14
9	Goods and Services	Invoice OCF-21, Version C must be used for billing goods and services within the guidelines of a Pre-approved Framework	IMBR-CS1
10	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
11	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
12	Measure	If section code is S, measure must be SN.	N/A
13	Measure	If section code is G, measure must be GD.	N/A
14	Measure	If intervention code is TT, measure must be HR.	N/A

Item #	Data Field	Description	Validation #
15	Measure	If intervention code is KM, measure must be KM.	N/A
16	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
17	Quantity	Quantity of a rendered Good or Service must be greater than 0.	IMBR-CS9
18	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
19	PAF Types	For an OCF-21C, the PAF type for an invoice must be the same as the PAF Type on the originating plan.	IMBR-CS28
20	Fees	For an OCF-21C, there must be a minimum of one reimbursable fee within the PAF guideline	IMBR-CS29
21	Fees	For an OCF-21C, PAF fee totals must equal the sum of the all individual reimbursable fees.	IMBR-CS30
22	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
23	Totals	For an OCF-21C, the other goods and services total must equal the sum of all the individual other reimbursable goods and services specified.	IMBR-CS31
24	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10
25	GST	Total GST must be greater than or equal to 0.	PM-CSR11
26	PST	Total PST must be greater than or equal to 0.	PM-CSR12
27	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	IMBR-CR1

Treatment Plan (OCF-18)

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

**Claim Number:

**Policy Number:

Date of Accident:
(YYYYMMDD)

*For this applicant, this is Treatment Plan number

from this health professional/facility or social worker

To the Applicant:

Please complete Parts 1 and 2. After your health professional or practitioner or social worker has reviewed your Treatment Plan with you, sign Part 14.

Your health professional/practitioner or social worker will complete all other parts of the form. A health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 5.

As indicated on the form, all attachments are sent directly to the insurer.

All fields must be completed subject to the following exceptions:

*required if known

**at least one field in this section

***optional

Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 1 Applicant Information

To be completed by
the applicant

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

Part 2 Insurance Company Information

To be completed by
the applicant

Insurance 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 Other Insurance Information

To be completed by
the health
professional or
social worker
responsible for plan
preparation and
supervision with
information from the
applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment Plan? I have made reasonable enquiries of the applicant and have determined that:		
☐ NO <i>There is no other insurance coverage identified for these goods and services</i> ☐ YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>		
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? ☐ Yes ☐ No ☐ Not applicable	
Other Insurer 1	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier
Other Insurer 2	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier

Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Treatment Plan if,

- i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and
- ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Note: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

Part 5 Signature of Health Practitioner Plan Certification

Name of Health Practitioner		College Registration Number		You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)		AISI Facility Number (if applicable)		
Address				
City	Province	Postal Code		
Telephone Number - -	*Extension	*Fax Number - -		
*Email Address				
☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan. or ☐ I am declaring the following conflicts of interest relating to this Treatment Plan:				
I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional or social worker in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.				
Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

Part 6 Signature of Regulated Health Professional or Social Worker Plan Preparation and Supervision If same person as Part 5 check here ☐ and **DO NOT COMPLETE Part 6**

Name of Regulated Health Professional or Social Worker		Registration Number		You are a: ☐ Chiropractor ☐ Dentist ☐ Massage Therapist ☐ Nurse ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Social Worker ☐ Speech-Language Pathologist ☐ Other _____
Facility Name (if applicable)		AISI Number (if applicable)		
Address				
City	Province	Postal Code		
Telephone Number - -	*Extension	*Fax Number - -		
*Email Address				
☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan. or ☐ I am declaring the following conflicts of interest relating to this Treatment Plan:				
I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.				
Name of Regulated Health Professional/Social Worker (please print)		Signature of Regulated Health Professional/Social Worker		Date (YYYYMMDD)

To the Health Professional or Social Worker:

Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. **Please print clearly.**

**Part 7
Injury and
Sequela
Information**

Provide a description (list most significant first) and associated ICD-10-CA† code for injuries and sequelae that are the direct result of the automobile accident.	
Description	Code
Notet: Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.	

**Part 8
Prior and
Concurrent
Conditions**

a)	Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 7? ☐ No ☐ Unknown ☐ Yes (please explain)
	If Yes to "a" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year? ☐ No ☐ Unknown ☐ Yes (please explain and identify provider, if known)
b)	Since the accident, has the applicant developed any other disease, condition or injury not related to the automobile accident that could affect his/her response to treatment for the injuries identified in Part 7? ☐ No ☐ Unknown ☐ Yes (please explain)
c)	Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? ☐ Yes ☐ No If yes, please provide a complete explanation, in accordance with the PAF Guidelines, and with express reference to the provisions of the PAF Guidelines on which you rely, why this OCF-18 Treatment Plan is being submitted instead of a Pre-approved Framework Treatment Confirmation Form (OCF-23/198).
Send any attachments directly to the insurer	

**Part 9
Activity
Limitations**

a)	Does the applicant's impairment(s) from the injuries identified in Part 7 affect his/her ability to carry out: His/her tasks of employment ☐ Not employed ☐ No ☐ Unknown ☐ Yes His/her activities of normal life ☐ No ☐ Unknown ☐ Yes
b)	If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function.
c)	If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant? ☐ Not employed ☐ Yes ☐ Unknown ☐ No (please explain)

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

a) **Goals:**

(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve:

- ☐ pain reduction
- ☐ increase in strength

and

(ii) Select the functional goal(s) that this Treatment Plan seeks to achieve:

- ☐ return to pre-accident work activities
- ☐ other(s) (please specify)

b) Evaluation:

(i) How will progress on the goal(s) in a (i) and a (ii) be evaluated?

(ii) *If this is a subsequent Treatment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

Send any attachments directly to the insurer

c) **Barriers to recovery:**

(i) Have you identified any other barriers to recovery? ☐ No ☐ Yes (please explain)

(ii) *Do you have any recommendations and/or strategies to overcome these barriers? ☐ No ☐ Yes (please explain)

d) **Concurrent Treatment:**

Are you aware if any concurrent treatment, that is not included in this Treatment Plan, will be provided by any other provider/facility?

☐ No ☐ Yes (please explain)

e) **Consistency:**

Are there any utilization guidelines applicable to the proposed treatment?

☐ Yes (Identify guideline):

☐ No (Please explain):

Part 14
Signature of
Applicant

Must be
completed
unless waived
by insurer

I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer.

In the event that my insurer does not agree to pay for all the goods and services contemplated in this treatment plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment Plan.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination (referred to in sections 24(1) 9 and 24.1(1) 2 of the Statutory Accident Benefits Schedule – On or After November 1, 1996). Separate express consent is required for this consultation. This consent should be in writing.

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)

Signature of Applicant or Substitute Decision Maker

Date (YYYYMMDD)

Auto Insurance Standard Invoice (OCF-21)

****Claim Number:**

****Policy Number:**

Date of Accident:
(YYYYMMDD)

Use this form for accidents that occur on or after November 1, 1996 for medical and rehabilitation goods and services that are payable by an automobile insurer. The User Manual for completion of the form and its versions may be found at www.hcaiinfo.ca.

Attach Version C - pages 2 and 3 for Pre-approved Frameworks (PAFs). Attach Version A - page 2 where there is a previously approved treatment or assessment plan. Version B - pages 2 and 3 must be used for all other goods and services and may be used for previously approved treatment plans and assessments, at the discretion of the provider.

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation. **As indicated on the form, all attachments are sent directly to the insurer.**

All fields must be completed subject to the following exceptions:

***required if known**

****at least one field in this section**

*****optional**

Part 1 Applicant Information

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

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 Invoice Information

*Invoice Number	
First Invoice	☐ Yes ☐ No
Last Invoice	☐ Yes ☐ No

For previously approved goods and services, please complete the following:

*Type of Plan or Pre-approved Framework	*Plan Date (YYYYMMDD)	*Plan Number	*Approved Amount	*Previously Billed
☐ Treatment Plan (OCF-18) ♦				
☐ Assessment Plan (OCF-22) ♦				
☐ PAF Type: ♦				
♦ Attach Version A or B ♣ Attach Version C		For all other Invoices, attach Version B		

Part 4 Payee Information

Facility Name (if applicable)		AISI Facility Number (if applicable)	
Payee Last Name		Payee First Name	Payee Number (if applicable)
Address			
City	Province	Postal Code	
Telephone Number - -	Extension	*Fax Number - -	
*Email Address			
☐ I wish to declare that I have no conflicts of interest relating to this invoice, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this invoice on the part of any person who referred the applicant to a person who provided goods or services referred to in this invoice. Or ☐ I am declaring the following conflicts of interest relating to this invoice:			
I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature and costs of goods and services that are provided to automobile accident victims, by health care providers; preventing fraud and detecting fraud where there are reasonable grounds to suspect fraud.			
Name of Health Professional Social Worker or Authorized Signatory (please print)		Signature of Health Professional Social Worker or Authorized Signatory	Date (YYYYMMDD)

This form may be used for billing goods and services that have been previously approved by the insurer through an OCF-18 or OCF-22.

This form may not be used for Pre-approved Frameworks (use Version C - pages 2 and 3) or goods and services that have not been previously approved (use Version B - pages 2 and 3).

Providers			Regulated (College Registration Number)	Unregulated (AIS) Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name				
A						
B						
C						
D						
E						
F						

Provider details are not required if they are the same as those on an approved plan.
Refer to the User Manual at www.hcalinfo.ca for coding.

[†] Refer to the previously approved plan for each good and service reference number (G/S Ref).

¹ Refer to the previously approved plan for each good and service reference number (G/S Ref). Enter the Provider Reference from the previously approved plan or the Provider table above at the intersection of the date of service and the G/S Ref indicating the provider who rendered or prescribed the service or good.

Make cheque payable to:	
***Other Information:	
Are there any attachments? ☐ Yes ☐ No	If yes, how many? _____
Send any attachments directly to the insurer	

Send any attachments directly to insurer

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18 or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

Provider details are not required if they are the same as those on a previously approved plan.
 *Refer to the User Manual at www.hcaiinfo.caca.ca for coding.

† Refer to the User Manual at www.hcaiinfo.ca for coding.

Sub-Total

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18 or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

Conflict of Interest Definition	A person has a conflict of interest relating to an invoice if: i. The person or a related person or another person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person, of the goods or services, and ii. The person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.
---	---

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

For insurer's use only		
Reviewed By:		
Approved By:		
Payee Name:		
Payment Amount:	Total	Interest Grand Total

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework. For all other goods and services attach Version A or B.

Providers			Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	*Hourly Rate	For Insurer's Use
Ref	*Type	Last Name First Name				
A						
B						
C						
D						
E						
F						
*Refer to the User Manual at www.hcainfo.ca for coding.						

† Refer to the User Manual at www.hcaiinfo.ca for coding.

OCF-21 - Version C - page 3

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework. For all other goods and services attach Version A or B.

Other Reimbursable Goods and Services Approved by the Insurer:											
Date of Service			Description	'Code	'Attribute	Provider Reference	Quantity	'Measure	GST (✓)	PST (✓)	Cost
YYYY	MM	DD									
Other Goods and Services Total:											

■ Refer to the User Manual at www.hcainfo.ca for coding.

Make cheque payable to:	
*** Other Information:	
Are there any attachments? ☐ Yes ☐ No Send any attachments directly to the insurer If yes, how many? _____	

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.

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.

As indicated on the form, all attachments are sent directly to the insurer.

All fields must be completed subject to the following exceptions:

***required if known**

****at least one field in this section**

*****optional**

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 or Social Worker

Name of Regulated Health Professional/Social Worker		College Registration Number	
Facility Name (if applicable)		AISI Facility Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number - -	Extension	*Fax Number - -	
*Email Address			
☐ 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 confirm 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/Social Worker (please print)		Signature of Regulated Health Professional/ Social Worker	Date (YYYYMMDD)

Part 4 Nature of Assessment or Examination

Except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline, payment for all assessments and examinations is dependent upon approval by the insurer or if disputed by an arbitration or by the courts. 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 cost of each assessment or examination does not exceed \$200.00, and
 - not more than one assessment or examination is done by the same person;
- ☐ 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.

***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.

***PRIOR APPROVAL MAY BE REQUIRED FOR 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 \$200.00;
- ☐ prior approval is required for assessments to complete disability certificates that exceed \$200.00.

***PRIOR APPROVAL IS NOT REQUIRED FOR 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.

***PRIOR APPROVAL MAY BE REQUIRED FOR 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.

***ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL:**

- ☐ prior approval is required for all other assessments not outlined.

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.

- ii. 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							
9							
10							
11							

Note: † Refer to the User Manual coding guidelines posted at www.hcaiinfo.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:	

Are there any attachments? ☐ Yes ☐ No If yes, how many? _____
Send any attachments directly to the insurer

Part 8 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 ☐ Do not approve

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 3 business days of receiving the completed form for proposed assessments:

1. Give the health professional or social worker and the applicant a notice approving the assessment or
2. Advise the applicant that the insurer is not agreeing to pay part or all assessments and advising the applicant that an examination is required.

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.

Part 9**Signature of
Applicant ***
(Optional)**

If not completed,
the Health
Professional or
Social Worker in
Part 3 assumes
responsibility for
obtaining
applicant's
consent

I have reviewed and confirm 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. In the event that my insurer seeks a further review of the application, my insurance company may require that I be examined by a health professional, social worker, or vocational rehabilitation expert identified by the insurer to review the application.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination (referred to in sections 24(1) 9 and 24.1(1) 2 of the Statutory Accident Benefits Schedule – On or After November 1, 1996). Separate express consent is required for this consultation. This consent should be in writing.

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)

Signature of Applicant or Substitute Decision Maker

Date (YYYYMMDD)

Pre-approved Framework Treatment Confirmation Form (OCF-23/198)

Use this form for accidents that occur on or after October 1, 2003

****Claim Number:**

****Policy Number:**

Date of Accident:
(YYYYMMDD)

To the Applicant:

Please complete Parts 1 and 2. After your health practitioner has reviewed your Treatment Confirmation Form with you, sign Part 13.

Your health practitioner will complete all other parts of the form. A health practitioner (chiropractor, dentist, occupational therapist, optometrist, physician, physiotherapist, nurse practitioner, psychologist, speech language pathologist) must sign Part 5.

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.

As indicated on the form, all attachments are sent directly to the insurer.

All fields must be completed subject to the following exceptions:

*required if known

**at least one field in this section

***optional

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 Other Insurance Information

To be completed
by the Initiating
Health
Practitioner with
Information from
the Applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Pre-approved Framework Treatment Confirmation Form? I have made reasonable enquiries of the applicant and have determined that: ☐ NO <i>There is no other insurance coverage identified for these goods and services</i> ☐ YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>		
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Confirmation Form? ☐ Yes ☐ No ☐ Not applicable	
Other Insurer 1	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier
Other Insurer 2	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier

Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Pre-approved Framework Treatment Confirmation Form if,
i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Pre-approved Framework Treatment Confirmation Form, and
ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Part 5 Signature of Initiating Health Practitioner

Name of Initiating Health Practitioner (please print)		College Registration Number	You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)		AIISI Facility Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number - -	Extension	*Fax Number - -	
*Email Address			
☐ I am not the first Initiating Health Practitioner Conflict of Interest Declaration ☐ I wish to declare that I have no conflicts of interest relating to this Pre-approved Framework Treatment Confirmation 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 Pre-approved Framework Treatment Confirmation Form:			
I certify that the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6, and the treatment proposed is in accordance with a PAF Guideline. I have reviewed the proposed treatment with the applicant. I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.			
Name of Initiating Health Practitioner (please print)		Signature of Initiating Health Practitioner	Date (YYYYMMDD)

To the Health Professional:

Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 6 Injury and Sequelae Information

Provide a description (list most significant first) and associated ICD-10-CA code for injuries and sequelae that are the direct result of the automobile accident.	
Injury Description	*Injury Code
Note *: Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.	

Part 7 Prior and Concurrent Conditions

a) Was the applicant employed at the time of the accident? ☐ Yes ☐ No
b) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 6? ☐ No ☐ Unknown ☐ Yes (please explain)
c) If Yes to "b" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year? ☐ No ☐ Unknown ☐ Yes (please explain and identify provider, if known)

Part 8 Barriers to Recovery

a) Have you identified any barriers to recovery that may affect the success of this treatment for this particular applicant? (For assistance in identifying barriers to recovery, please refer to the user manual at www.hcaiinfo.ca .) ☐ No ☐ Yes (please explain)

Applicant Name:		OCF23/198 - FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 9 PAF Pre-approved Services			
Category	Description	Maximum Fee	Estimated Fee
PAF (identify which PAF Guideline)			
*Supplementary Goods & Services			
*Other Pre-approved Services (including radiology)			
Part 9 Sub-Total			

***Part 10 Other Health Providers**
(required only if Part 11 Services are rendered by Other 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						

***Part 11 Other Goods or Services Within the PAF Guidelines Requiring Insurer Approval**

Description	†Code	†Attribute	Provider Reference	Estimated		
				Quantity	†Measure	Cost
Note: † Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca . Attributes codes are used to further qualify the service codes and are described in the manual.				Part 11 Sub-Total:		
Payment by auto insurer is secondary to available collateral benefits.				Total:		
Briefly explain why the goods and services in Part 11 are being proposed and the treatment goal:						

Are there any attachments? ☐ Yes ☐ No If yes, how many? _____
 Send any attachments directly to the insurer

Part 12 Signature of Insurer

☐ ***I waive the requirement of the Applicant's signature.		
☐ I have reviewed this Pre-approved Framework Treatment Confirmation Form, and based upon the information provided, I confirm that the policy referred to in Part 2 was in force at the time of the accident.		
If other goods or services requiring insurer approval have been proposed in Part 11, I		
☐ Approve	☐ Partially approve (explanation to follow or attached)	☐ Do not approve (explanation to follow or attached)
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
To the insurer: Please provide a copy of this page to the Applicant and the Initiating Health Practitioner indicated in Part 5.		

Part 13
Signature
of
Applicant

I have reviewed this form. I have been informed about and agree with the proposed treatment. I certify that, to the best of my knowledge, the information I have provided is accurate. Payment for this treatment is pre-approved, and/or subject to the approval of the insurer. For services requiring insurer approval, I understand that, if I undertake those services prior to approval by the insurer, I may be responsible to my provider for any goods or services provided. All services are subject to coverage issues or exclusions.

I consent to sharing of personal information between my Initiating Health Practitioner and my insurer. If this OCF-23/198 is not being completed by the first Initiating Health Practitioner, I consent to the insurer contacting the first Initiating Health Practitioner to determine the amount of the PAF goods and services that have been consumed.

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.

I ALSO UNDERSTAND that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information only as reasonably necessary to enable you to carry out the purposes described above:

- Insurers; insurance adjusters; agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; and my agents or representatives as designated by me from time to time.

I CONSENT to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have questions about this consent I am free to consult my insurance company representative or legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

I certify that the information provided is true and correct.

I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

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