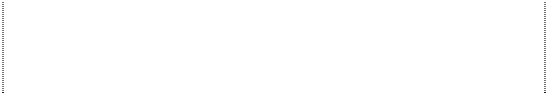
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| --- | --- |
|  | |
| **Auto Insurance Standard Invoice**  **(OCF-21)**  Use this form for accidents that occur on or after November 1, 1996 | |
| **\*\*Claim Number:** |  |
| **\*\*Policy Number:** |  |
| **Date of Accident:**  **(YYYYMMDD)** |  |

To be used 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.](http://www.hcaiinfo.ca/)

Confidentiality: Collection, use and disclosure of this information are 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**

Attach Version C - pages 2 and 3 for Minor Injury Guideline for accidents that occurred on or after September 1, 2010 or Pre-Approved Framework (PAF) treatments for accidents that occurred prior to September 1, 2010.

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.

**Part 1 Applicant Information**

Date Of Birth (YYYYMMDD) Last Name

First Name

Gender

Male Female

\*\*\* Middle Name

**\***Telephone Number Extension

Address

City

Province

Postal Code

## Part 2 Insurance Company Information

Company Name

**\***Adjuster Last Name

**\***Adjuster Telephone Extension

City or Town of Branch Office (if applicable)

**\***Adjuster First Name

**\***Adjuster Fax

**\*\***Name of Policy Holder same as: Applicant OR

**\*\***Policy Holder Last Name

**\***Policy Holder First Name

**Part 3 Invoice**

# 

**Invoice Number**

**First Invoice**

Yes

No

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

#### Last Invoice

Yes No

**Information**

#### \*Type of Plan or Minor Injury Guideline or Pre-approved Framework Treatments

Treatment and Assessment Plan (OCF-18) 

#### \*Plan Date

**(YYYYMMDD)**

#### \*Plan Number

**\*Approved Amount**

**\*Previously Billed**

## Part 4

**Payee Information**

Minor Injury Guideline or PAF

* Attach Version A or B

 Attach Version C

|  |  |  |
| --- | --- | --- |
| 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 |  |  |

Type:



For all other Invoices, attach Version B

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 Provider or Authorized Signatory (please print) Signature of Provider or Authorized Signatory Date (YYYYMMDD)

**SAVE**

Effective date (2010/09/01) FSCO 1208E

OCF-21

Page 1 of 6

## OCF-21 - Version A - page 2

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

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Injuries and Sequelae** | |  | **Providers** | | | | **Regulated**  (College Registration Number) | **Unregulated**  (AISI Number if applicable, or blank) | **Hourly Rate** | **For Insurer's Use** |
| **Description** | **†Code** | **Ref** | **†Type** | **Last Name** | **First Name** |
|  |  | A |  |  |  |  |  |  |  |
|  |  | B |  |  |  |  |  |  |  |
|  |  | C |  |  |  |  |  |  |  |
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|  |  | E |  |  |  |  |  |  |  |
|  |  | F |  |  |  |  |  |  |  |
| Injury details are not required if they are the same as those on an approved plan.  **†** Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | | Provider details are not required if they are the same as those on an approved plan.  **†** Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | | | | | | | |

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| **†G/S**  **Ref** | **Month** (yyyy-mm): | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **Tax** | **Cost/ Day** | **Total Count** | | **Total Cost** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
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| **†** 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Insurance**  (for goods and services on this invoice) |  | MOH | Insurer 1 | Insurer 2 | **Account Activity since Last Invoice**  (if interest is being charged) | | **Sub-Total:** |  |
| Chiropractic: |  |  |  | **MOH:** |  |
| Physiotherapy: |  |  |  | Prior Balance: |  | **Other Insurer 1 + 2:** |  |
| Massage Therapy: |  |  |  | Payment Received from Auto Insurer: |  | **Tax** *(if applicable)***:** |  |
| **1**Other Service Type: |
| **Total:** |  |  |  | **2**Overdue Amount: |  | **2Interest:** |  |
| **1**Please Specify Other  Service Type: |  | | | **2**The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule. | | **Auto Insurer Total:** |  |

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

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

Effective date (2010/09/01) FSCO 1208E

**SAVE**

OCF-21

Page 2 of 6

## OCF-21 - Version B - page 2

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.

They may be used, at the discretion of the provider, for billing any goods or services except for Minor Injury Guideline or Pre-approved Frameworks Treatments (use Version C - pages 2 and 3).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Injuries and Sequelae** | |  | **Providers** | | | | **Regulated**  (College Registration Number) | **Unregulated**  (AISI Number if applicable, or blank) | **Hourly Rate** | **For Insurer's Use** |
| **Description** | **†Code** | **Ref** | **†Type** | **Last Name** | **First Name** |
|  |  | A |  |  |  |  |  |  |  |
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|  |  | C |  |  |  |  |  |  |  |
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|  |  | F |  |  |  |  |  |  |  |
| Injury details are not required if they are the same as those on a previously approved plan.  **†**Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | | 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.ca](http://www.hcaiinfo.ca/)ca for coding. | | | | | | | |

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| **Date of Service** | | | **Description** | **†Code** | **†Attribute** | **Provider Reference** | **Quantity** | **†Measure** | **Tax (****)** | **Cost** |
| **YYYY** | **MM** | **DD** |
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| † Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | | | | | | | **Sub-Total** | | |  |

**Send any attachments directly to insurer**

**SAVE**

Effective date (2010/09/01)

OCF-21

## OCF-21 - Version B - page 3

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.

They may be used, at the discretion of the provider, for billing any goods or services except Minor Injury Guideline or Pre-approved Framework Treatments (use Version C - pages 2 and 3).

**Other Insurance**

(for goods and services on this invoice)

|  |  |  |
| --- | --- | --- |
| **OTHER INSURANCE:** I have made reasonable enquiries of the claimant and have determined that:  **NO** *There is no other insurance coverage* **YES** *There is other insurance coverage that is potentially available to identified for these goods and services cover/partially cover these goods and services.* | | |
| MOH | Is there Ministry of Health and Long-Term Care (MOH) coverage for goods and services included in this invoice?  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 |
| Other Insurance details are not required if they are the same as those on a pre-approved plan. | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | MOH | Insurer 1 | Insurer 2 | **Account Activity since Last Invoice**  (if interest is being charged) | | **Sub-Total:** |  |
| Chiropractic: |  |  |  | **MOH:** |  |
| Physiotherapy: |  |  |  | \*Prior Balance: |  | **Other Insurer 1 + 2:** |  |
| Massage Therapy: |  |  |  | \*Payment Received from Auto Insurer: |  | **Tax** *(if applicable)***:** |  |
| **1**Other Service Type: |  |  |  |
| **Total:** |  |  |  | **2**Overdue Amount: |  | **2Interest:** |  |
| **1**Please Specify Other  Service Type: |  | | | **2**The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule. | | **Auto Insurer Total:** |  |

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

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

**SAVE**

Effective date (2010/09/01) OCF-21

## OCF-21 - Version C - page 2

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

|  |  |
| --- | --- |
| **Injuries and Sequelae** | |
| **Description** | **†Code** |
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| Injury details are not required if they are the same as those on the Treatment Confirmation Form (OCF-23)  **†**Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | |
|  | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | | | | | | | |
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| **Goods and Services Rendered** (Minor Injury Guideline or Pre-approved Framework Treatments, providers are required to declare the information requested below on every treatment, service and good delivered. Failure to provide this information may delay payment) | | | | | | | | |
| **Date of Service** | | | **Description** | **†Code** | **†Attribute** | **Provider**  **Reference** | **Quantity** | **†Measure** |
| **YYYY** | **MM** | **DD** |
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† **Refer to the User Manual at** [**www.hcaiinfo.ca**](http://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 Minor Injury Guideline or Pre-approved Framework. For all other goods and services attach Version A or B.

|  |  |  |  |
| --- | --- | --- | --- |
| **Reimbursable Fees Within the Minor Injury Guideline or Pre-Approved Framework:** | | | |
| **Description** | **†Code** | **†Attribute** | **Cost** |
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| **†**Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca/) for coding. | **Minor Injury Guideline or Pre- approved Framework Fee Totals:** | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Reimbursable Goods and Services Approved by the Insurer:** | | | | | | | | | | | |
| **Date of Service** | | | **Description** | **†Code** | **†Attribute** | **Provider Reference** | **Quantity** | **†Measure** | **Tax (****)** |  | **Cost** |
| **YYYY** | **MM** | **DD** |
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|  Refer to the User Manual at [www.hcaiinfo.c](http://www.hcaiinfo.ca/)a for coding. | | | | | | | **Other Goods and Services Total:** | | | |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Other Insurance (for goods and services on this invoice) |  | MOH | Insurer 1 | Insurer 2 | **Account Activity since Last Invoice** | | **Sub-Total:** |  |
| Chiropractic: |  |  |  | **MOH:** |  |
| (if interest is being charged) | |
| Physiotherapy: |  |  |  | Prior Balance: |  | **Other Insurer 1 + 2:** |  |
| Massage Therapy: |  |  |  | Payment Received |  | **Tax** *(if applicable)***:** |  |
| **1**Other Service Type: |  |  |  | from Auto Insurer: |  |  |
| **Total:** |  |  |  | **2**Overdue Amount: |  | **2Interest:** |  |
| **1**Please Specify Other  Service Type: |  | | | **2**The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule. | | **Auto Insurer Total:** |  |

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

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