					Auto Ins	ura	ince S	stand		Invoice OCF-21)	
							accidents that	t occur or	or after I	November 1, 1996.	
					**Claim Nu	ımber:					
					**Policy Nu						
					Date of Acc (YYY)	cident: (MMDD)					
by an automobile	edical and rehabilitation goods and services the insurer. The User Manual for completion of the ound at www.hcaiinfo.ca.		d its o	r after \$	/ersion C - pages 2 an September 1, 2010. /ersion A - page 2 whe						
	ollection, use and disclosure of this information	n are subj		Attach Version A - page 2 where there is a previously approved treatment or assessment plan.							
all applicable priva	, ,		fr	Version B - pages 2 and 3 must be used for all other goods and services and may be use for previously approved treatment plans and assessments, at the discretion of the							
As indicated on t	the form, all attachments are sent directly	to the ins		rovider		unent p	Dians and as	36331116111	s, at the	discretion of the	
	e completed subject to the following except to the following except to the feet one field in this section ***op										
Part 1	Date Of Birth (YYYYMMDD)	Gend		Male	Female	*Tel	lephone Numbe	r		Extension	
Applicant Information	Last Name			iviale	i emale						
	First Name		***	Middle N	Name						
	Address										
	City	Provir	nce			Posi	tal Code				
Part 2	Company Name			City or Town of Branch Office (if applicable)							
Insurance Company	*Adjuster Last Name			*Ac	djuster First Name						
Information	*Adjuster Telephone Extension	n		*Ac	djuster Fax						
	**Name of Policy Holder same as:	y Holder Las	st Name	l	*Policy Holder First	Name					
Part 3	Invoice Number		First In	voice	Yes No			Last Inv	oice	Yes No	
Invoice Information	For previously approved goods an	d service	es, please	comp	olete the following	:					
illiorillation	*Type of Plan or Minor Injury Guideline		*Plan Dat		Plan Number		*Approved	Amount	*Pı	eviously Billed	
	Treatment and Assessment Plan (OCF-18)	•									
	Minor Injury Type:										
	Attach Version A or B Attach Version C	For all	other Invoices	attach '	Version B			,			

Part 4 Payee Information

If Service Address is same as Billing Address check here and DO NOT COMPLETE Service Address

*Email Address

Facility Name (if applicable)			HCAI Facility Registry Number	FSCO Lice	Licence Number (if applicable)			
Payee Last Name	Payee First Name Payee Number (if appl							
Billing Address			Service Address (place where service	ss (place where service is provided, but not patient address)				
City	Province	Postal Code	City		Province	Postal Code		
Telephone Number		Extension	*Fax Number					

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you and persons acting for you, will collect business, personal and personal health information that is related to the applicant's claim for accident benefits arising out of the accident referenced in this invoice and that all such information will be collected directly from me or from any other person with my consent.

I ALSO UNDERSTAND that you and persons acting for you will collect information about this invoice prepared by me.

I ALSO UNDERSTAND that if I am the health service provider for the applicant that you, and persons acting for you, will collect information related to this claim that is provided by me on this invoice or any other auto insurance application form.

I ALSO UNDERSTAND that the information within this form will be collected and used only as reasonably necessary, with the applicant's consent for the purposes of:

- Investigating the claims of the applicant and processing the claims of the applicant as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to the applicant's 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 the applicant's claims:
- Identifying and analysing the nature and costs of goods and services that are provided to automobile insurance claimants by health care providers;
- Preventing, detecting and suppressing 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 or organizations, who may collectand use this information only as reasonably necessary to enable you or them to carry out the purposes described above:

Insurers; insurance adjusters, agents and brokers; employers; health care providers; hospitals; accountants; financial advisors; solicitors:

organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations; other insurance

companies; the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.

I ALSO UNDERSTAND that you, and persons acting for you, may pool this information with information from other sources and may analyze this information for the limited purpose of preventing, detecting or suppressing fraud.

I CONSENT to you collecting, using and disclosing information relating to this claim form in the manner described above, which will be limited to information that is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with the insurance company representative or a 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. Regulated sectors may be subject to an examination or inquiry about matters in connection with a licence and or unfair or deceptive act or practice. Non-compliance with applicable regulations may result in enforcement actions ranging from an administrative monetary penalty to prosecution under the Provincial Offences Act.

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 PREVENTING, DETECTING AND SUPPRESSING FRAUD.

To obtain further information about privacy related issues please contact the Privacy Officer at the insurance company listed in Part 2.

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit http://www.ibc.ca/en/privacy-terminology.asp

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

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 (use Version C - pages 2 and 3) or for goods and services that have not been previously approved (use Version B - pages 2 and 3).

Injuries and Sequelae Pro											ovide	viders					Regulated (College Registra				Hourly Rate	For Insurer's													
			Des	cripti	on					†Co	de		Re	ef	†Туре			Las	st Nam	ne				First	Name			(Colle	ege Re Numb		on		blank)	,	Use
													A																						
													B																						_
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													Е																						
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Injury de	etails ar o the U	e not re ser Ma	equired nual at	if they www.h	are the	e same o.ca for	e as tho coding	ose on J.	an app	roved p	olan.						require ual at <u>w</u>					nose or	an ap	proved	plan.										
†G/S	Mor	nth (yy	yy-mm)	:																												_	Cost/	Total	Total
Ref	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	Tax	Day	Count	Cost
		<u> </u>						-			<u> </u>		ļ						ļ	ļ										<u> </u>					
		<u> </u>						-			<u> </u>		-						-	-							-			<u> </u>					
						1									-							-					1				1				
							1		+						1							1													
			1		1		1		+												1														
†Refer t															1							1						1			1	ı	- I		
Enter th	e Provid	der Ref	ference	from t	he prev	viously	approv	ved pla	n or th	e Provid	der tab	le abov	e at the	e inters	section	of the	date of	service	e and t	he G/S	Ref in	dicatin	g the p												
Enter amounts that have or will be paid by "other" insurers, which will be Enter amounts assigned to "other" insurers on prior invoices that Amount will be added to this invoice total.													e not paid.																						
es es											de	educt	ed fro	om th	is inv	oice t	total.							١	Note:	Auto								iolai. Idded to invol	ce total.
Other Insurance goods and services	<u></u>							MC	ΣΗ				Inst	ırer 1	1			I	nsur	er 2					MC							irer 1			ırer 2
se	his invoice)				ractio																														
l lns	.≧				erapy																														
ds s	his		assag er Se								_																		-						
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																	Ac	cou	nt A	ctivi	ty si	nce	Last	Invo	oice							Su	ıb-Total:		
																							arged)										MOH:		
																				Prior	Bala	nce:								0	ther	Insu	ırer 1+2:		
															Pay	ment	t Rec	eived	l from	Auto) Insu	ırer:								7	Гах (olicable):		
																			² Ove	erdue	Amo	ount:										²	Interest:		
																	pay inte Schedu		n overd	due out	standir	ng bala	nces a	s requi	red by t	he Sta	atutory			Αι	uto l	nsur	er Total:		
Make	che	que p	oayal	ole to) :																								For	insu	rer's	use	only		
***Oth	ner In	form	ation	1:						-													F	Revie	wed	Ву:									
																									oved										
Are th	nere a	ny at	ttach	ment	s?] Yes	sГ	□No	If	yes.	how	man	y?												e Nar										
Are there any attachments? Yes No If yes, how many? Send any attachments directly to the insurer												F			Amoı						tal:														

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 (use Version C - pages 2 and 3).

Injuries and Sequelae										
Description	⁺Code									

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 for coding.

		Providers		Regulated (College Registration Number)	Unregulated (If applicable, or blank)	Hourly Rate	For Insurer's Use	
Ref	⁺Type	Last Name	First Name	Number)	blank)		FOI IIISUIEI S OSE	
Α								
В								
С								
D								
Е								
F								
						•		

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, for coding.

Date of Service		ice	Description			Provider	Ougatitus	Massura	Tax	Cost
YYYY	MM	DD	Description	⁺Code	 +Attribute	Reference	Quantity	⁺Measure	(✔)	Cost
					L					
Refer to the	he User Manu	al at www.hc	aiinfo.ca for coding.		Sub-Total					

Send any attachments directly to insurer

OCF-21 - Version B - page 3

ersion B - pages 2 ney <u>may be used,</u>	2 and 3 are used together for bill at the discretion of the provider	ing goods and services that ha , for billing any goods or servic	ve not been previously appress except for Minor Injury G	roved by the i uideline (use	insurer through an OCF-18. Version C - pages 2 and 3).				
OTHER II	NSURANCE: I have ma	ade reasonable enquiries	of the claimant and ha	ave determ	nined that:				
□NO	There is no other insural identified for these goods	nce coverage [s and services	YES There is othe cover/partially	er insurand cover the	ce coverage that is potentions is a goods and services.	ally available to			
МОН	Is there Ministry of He			goods and	d services included in this in	nvoice?			
Other Insurer	*Other Insurer Name				Plan Or Policy Number				
1	*Name of Plan Member		*Othe	er Insurer's Id	dentifier				
Other	*Other Insurer Name		*Othe	er Insurance I	Plan Or Policy Number				
Insurer 2	*Name of Plan Member		*Othe	er Insurer's Id	dentifier				
Other Insura	ance details are not required if the	ney are the same as those on a	pre-approved plan.						
r Insurance s and services on is invoice)		Enter amounts the	at have or will be paid deducted from this		r" insurers, which will be otal.		Amount	"other" insurers on prior invoi will be added to this invoice to y request EOB for amounts ac	otal.
Other Insurance goods and service this invoice)		MOH	Insurer 1		Insurer 2		10H	Insurer 1	Insurer 2
nsurai ind servinvoice	Chiropractic:								
nd 8	Physiotherapy:								
ds ar	Massage Therapy:								
Othe goods	¹ Other Service Type: Total:								
(for g	¹ Please Specify Other Service Type:		1						
						y since Last Investigations	oice	Sub-Total:	
					(ii iiiterest i	s being charged)		MOH:	
					*Prior l	Balance:		Other Insurer 1+2:	
				*Paym	nent Received from Auto	Insurer:		Tax (if applicable):	
					² Overdue	Amount:		² Interest:	
					urer shall pay interest on overdue y Accident Benefits Schedule.	e outstanding balances as	required by the	Auto Insurer Total:	
Make che	eque payable to:						For	insurer's use only	
***Other I	nformation:					Reviewed	d By:		
						Approved	d By:		
		_				Payee Na			
	any attachments? 🔲 ነ attachments directly to		how many?	_		Payment Amo		Total Interest	Grand Total
Effective da	ate (2016-10-01) © Quee	en's Printer for Ontario	2016					1	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. For all other goods and services attach Version A or B.

Injuries and Sequelae								
Description	†Code							

		Providers		Regulated (College Registration	Unregulated	*Hourly Rate	For Insurer's Use	
Ref	†Туре	Last Name	First Name	Number)	(If applicable, or blank)		For insurer's Use	
Α								
В								
С								
D								
Е								
F								
Г								

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 for coding.

Da	te of Servic		Description	†Code	†Attribute	Provider	Quantity	⁺Measure
YYYY	MM	DD		Code	Attribute	Reference	Quantity	Wicasard

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

[†]Refer to the User Manual at <u>www.hcaiinfo.ca</u> 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.
For all other goods and services attach Version A or B.

The trial group and controls distant volument of Di											
Reimbursable Fees Within the Minor Injury Guideline:											
First	Date of Se	ervice	Description		†Code		Provider Reference		Cost		
YYYY	MM	DD	Description		Todae	Provider 1	Provider 2	Provider 3	0031		
†Refer to the User Manual at www.hcaiinfo.ca for coding. Minor Injury Guideline Fee Totals:											
			_			•	•				

Other Insurance (for goods and services on this invoice)		Enter amounts that have or will be paid by "other" insurers, which will be deducted from this invoice total.			Enter amounts assigned to "other" insurers on prior invoices that were not paid. Amount will be added to this invoice total. Note: Auto Insurers may request EOB for amounts added to invoice total.		
		MOH	Insurer 1	Insurer 2	МОН	Insurer 1	Insurer 2
	Chiropractic: Physiotherapy: Massage Therapy: 10ther Service Type:						
	Total:						
	¹ Please Specify Other Service Type:						

Account Activity since Last Invoice	Sub-Total:	
(if interest is being charged)	MOH:	
Prior Balance:	Other Insurer 1+2:	
Payment Received from Auto Insurer:	Tax (if applicable):	
² Overdue Amount:	² Interest:	
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	_ , ,	
Send any attachments directly to the i	insurer	

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