



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.

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.

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) | Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Applicant OR | **Policy Holder Last Name | *Policy Holder First Name | |

Part 3 Invoice Information

| | | | | |
|---|--|---|------------------|--------------------|
| Invoice Number | First Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No | Last Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| For previously approved goods and services, please complete the following: | | | | |
| *Type of Plan or Minor Injury Guideline | *Plan Date (YYYYMMDD) | Plan Number | *Approved Amount | *Previously Billed |
| <input type="checkbox"/> Treatment and Assessment Plan (OCF-18) ♦ | | | | |
| <input type="checkbox"/> Minor Injury Guideline | Type: * | | | |
| ♦ Attach Version A or B | | For all other Invoices, attach Version B | | |
| * Attach Version C | | | | |

**Part 4
Payee
Information**

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

| | | | | | | |
|---|----------|-------------|--|-------------|-------------------------------------|--|
| Facility Name (if applicable) | | | HCAI Facility Registry Number | | FSRA Licence Number (if applicable) | |
| Payee Last Name | | | Payee First Name | | Payee Number (if applicable) | |
| Billing Address | | | Service Address (place where service is provided, but not patient address) | | | |
| City | Province | Postal Code | City | Province | Postal Code | |
| Telephone Number | | Extension | | *Fax Number | | |
| *Email Address | | | | | | |
| <p>TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:</p> <p>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.</p> <p>I ALSO UNDERSTAND that you and persons acting for you will collect information about this invoice prepared by me.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons or organizations, who may collect and use this information only as reasonably necessary to enable you or them to carry out the purposes described above:</p> <p>Insurers; insurance adjusters, agents and brokers; employers; health care providers; hospitals; accountants; financial advisors; solicitors;</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.</p> <p>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.</p> <p>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.</p> <p>To obtain further information about privacy related issues please contact the Privacy Officer at the insurance company listed in Part 2.</p> <p>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</p> | | | | | | |
| Name of Provider or Authorized Signatory (please print) | | | Signature of Provider or Authorized Signatory | | Date (YYYYMMDD) | |

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 for Minor Injury Guideline (use Version C - pages 2 and 3).

OTHER INSURANCE: I have made reasonable enquiries of the claimant and have determined that:

NO There is no other insurance coverage identified for these goods and services **YES** There is other insurance coverage that is potentially available to 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

| 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 | MOH | Insurer 1 | Insurer 2 |
| | Chiropractic: | | | | | |
| Physiotherapy: | | | | | | |
| Massage Therapy: | | | | | | |
| ¹ Other Service Type: | | | | | | |
| Total: | | | | | | |
| ¹ Please Specify Other Service Type: | | | | | | |

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

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

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.

| Reimbursable Fees Within the Minor Injury Guideline: | | | | | | | | |
|---|----|----|-------------|------------------------------------|--------------------|------------|------------|------|
| First Date of Service | | | Description | †Code | Provider Reference | | | Cost |
| YYYY | MM | DD | | | Provider 1 | Provider 2 | Provider 3 | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| †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 | MOH | Insurer 1 | Insurer 2 | |
| | Chiropractic: | | | | | | |
| | Physiotherapy: | | | | | | |
| | Massage Therapy: | | | | | | |
| | ¹ Other Service Type: | | | | | | |
| Total: | | | | | | | |
| ¹ Please Specify Other Service Type: | | | | | | | |

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

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