**Return this form to:**

# Treatment and Assessment Plan (OCF-18)

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

| | |
|---|---|
| ****Claim Number:** | |
| ****Policy Number:** | |
| **Date of Accident:** (YYYYMMDD) | |

**NOTE:** A Treatment and Assessment Plan (OCF- 18) is not required to make the following claims:

- ambulance or other goods or services provided on an emergency basis not more than 5 business days after the accident.
- drugs prescribed by a regulated health professional
- goods with a cost of $250 or less per item
- dental goods or services (submitted on the Standard Dental Claim Form)

**If this is an impairment that comes within the Minor Injury Guideline applicable to the accident (for accidents that occurred on or after September 1, 2010), or within a Pre-approved Framework Guideline (for accidents that occurred before September 1, 2010), an OCF – 23 Treatment Confirmation Form is required instead of this form.**

**To the Applicant:**
Please provide information for the completion of Parts 1 and 2 and 3. After your regulated health professional has reviewed your Treatment and Assessment Plan with you, sign Part 10.

Your regulated health professional will complete all other parts of the form.

Collection, use and disclosure of this information are 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**

**To the Regulated Health Professional/Facility:**
To the extent possible, this Treatment and Assessment Plan should include all goods and services contemplated by the regulated health professional referred to in Part 5.

A health practitioner (i.e., chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 4.

**Consent:** It is the responsibility of regulated health professionals to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Ontario Claims Form 5 (OCF – 5) *Permission to Disclose Health Information* may be used as a consent form.

## Part 1 Applicant Information

To be provided 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 provided 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 regulated health professional referred to in Part 5 with information from the applicant

**OTHER INSURANCE:** Is there other insurance coverage for any goods and services listed in this Treatment and Assessment Plan?
I have made reasonable enquiries of the applicant 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 any goods and services included in this 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 Signature of Health Practitioner

Treatment and Assessment Plan Certification

| Name of Health Practitioner | | College Registration Number | |
|---|---|---|---|
| Facility Name (if applicable) | | | |
| HCAI Facility Registry Number (if applicable) | | FSCO Licence Number (if applicable) | |
| Service Address | | | |
| City | | Province | Postal Code |
| Telephone Number | *Extension | *Fax Number | *Email Address |

**You are a:**
- ☐ Chiropractor
- ☐ Dentist
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Physician
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Speech-Language Pathologist

For accidents that occurred before September 1, 2010:

Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? ☐ Yes ☐ No

If yes, please explain, in accordance with the PAF Guideline, and with express reference to the provisions of the PAF Guideline on which you rely, why this OCF-18 Treatment and Assessment Plan is being submitted instead of an OCF 23 Treatment Confirmation Form:

For accidents that occur on or after September 1, 2010:

Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline applicable to the accident? ☐ Yes ☐ No

If yes, please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that was documented by me or another health practitioner before the accident and that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

**Send any attachments directly to the insurer**

I confirm that, to the best of my knowledge, the information in this Treatment and Assessment Plan is accurate, the Treatment and Assessment Plan has been reviewed with the applicant by the regulated health professional in Part 5, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6.

**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 5 Signature of Regulated Health Professional

Treatment and Assessment Plan Preparation and Supervision

If same person as Part 4 check here ☐ and ***DO NOT COMPLETE Part 5***

| Name of Regulated Health Professional | | College Registration Number | |
|---|---|---|---|
| Facility Name (if applicable) | | | |
| HCAI Facility Registry Number | | FSCO Licence Number (if applicable) | |
| Service Address | | | |
| City | | Province | Postal Code |
| Telephone Number | *Extension | *Fax Number | |
| *Email Address | | | |

**You are a:**
- ☐ Chiropractor
- ☐ Dentist
- ☐ Massage Therapist
- ☐ Nurse
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Physician
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Speech-Language Pathologist
- ☐ Social Worker
- ☐ Other _____

**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 (please print) | Signature of Regulated Health Professional | Date (YYYYMMDD) |
|---|---|---|
| | | |

**To the Regulated Health Professional referred to in Part 5:**
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 complaints, injuries and sequelae that are the direct result of the automobile accident (refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information).

| Description | Code |
|---|---|
| | |
| | |
| | |
| | |

## Part 7 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 6?

☐ 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 6?

☐ No ☐ Unknown ☐ Yes (please explain)

**Send any attachments directly to the insurer**

## Part 8 Activity Limitations

a) Does the applicant's impairment(s) from the injuries identified in Part 6 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 9
## 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 and Assessment Plan seeks to achieve:

- ☐ pain reduction
- ☐ increased range of motion
- ☐ increase in strength
- ☐ other(s)/not applicable (please specify)

**and**

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

- ☐ return to activities of normal living
- ☐ return to pre-accident work activities
- ☐ return to modified work activities
- ☐ other(s)/not applicable (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 and Assessment 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 not included in this Treatment and Assessment Plan will be provided by any other provider/facility?

☐ No ☐ Yes (please explain)

## Part 10
## Signature of Applicant

Must be completed unless waived by insurer

I have reviewed and agree with this Treatment and Assessment Plan. I understand that payment for this Treatment and Assessment 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 and Assessment Plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment and Assessment Plan.

In the event that an examination is requested, I authorize my insurer and my health care providers to give the person 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 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.

**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) |
|---|---|---|
| | | |

| Applicant Name: | | OCF-18<br>INSURER FAX BACK | Policy Number: | |
|---|---|---|---|---|
| Provider Name: | | | Claim Number: | |
| Provider Fax: | | | Date of Accident: | |

## Part 11 Health Care Providers

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

## Part 12 Proposed Goods or Services Requiring Insurer Approval

To the extent possible, this Treatment and Assessment Plan should include **all goods and services (G/S)** contemplated by the Regulated Health Professional referred to in Part 5 for the period of this Treatment and Assessment Plan

| G/S Ref | Description | †Code | †Attribute | Provider Ref | Estimated | | | Projected | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Quantity | †Measure | Cost | Total Count | Total Cost |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |

| | | | |
|---|---|---|---|
| **Estimated duration of this Plan:** | **Weeks** | **Sub-Total:** | |
| ***How many visits have you already provided:** | ***visits** | **Minus MOH:** | |
| **Note:** † Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca. | | **Minus Other Insurer 1+2:** | |
| Attributes codes are used to further qualify the service codes and are described in the manual. | | **TAX (if applicable):** | |
| Payment by auto insurer is secondary to available collateral benefits. | | **Auto Insurer Total:** | |

Applicant or Substitute Decision Maker confirms consent to proposed goods and services: **Initials**:

*Please indicate any additional comments regarding proposed goods and services:

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

## Part 13 Signature of Insurer

☐ ***I waive the requirement of the Applicant's signature.

I have reviewed this Treatment and Assessment Plan and based upon the information provided, I:

☐ Approve this Treatment and Assessment Plan ☐ Partially approve ☐ Do not approve

The Statutory Accident Benefits Schedule states that the insurer shall, within 10 business days of receiving this Treatment and Assessment Plan, give the applicant a notice stating the goods and services contemplated by the Treatment and Assessment Plan for which the insurer will or will not pay.

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

**To the insurer**: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 4 and the Regulated Health Professional indicated in Part 5.

**Note:** 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. The Regulated Health Professional referred to in Part 5 will contact each of the health care providers listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment and Assessment Plan.