The User Manual for this form may be found at www.standardinvoice.on.ca.

Auto Insurance Standard Invoice (OCF-21/59)

Invoice Date	year	month	day

Facility Invoice Number/Reference

Is this the first invoice for this claimant? ☐ Yes ☐ No

Use of this form is for accidents that occur on or after November 1, 1996. This form applies to applicable medical and rehabilitation goods and services that are billed directly to an insurer by a health care provider or facility, or are included in a treatment plan, or are for the first 15 physiotherapy or chiropractic treatment sessions provided within 6 weeks of the accident. This form also applies to specified assessments, examinations, reports, treatment plans and attendant care provided by health care providers. Instructions on the completion of this form are set out in the User Manual available at www.standardinvoice.on.ca.

Consent: It is the responsibility of the provider and the facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form or otherwise. Providers and facilities should use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form.

Part 1 Facility (Biller) Information

Facility Number	GST Number
Facility Name	
Address	
City	Province / Postal Code
Telephone Number / Extension / Fax Number	
E-mail Address	

Facilities without a registration number may obtain one at www.aisiregistration.on.ca.

This invoice is for:

- ☐ **Treatment**
- ☐ **Insurer Examination**
- ☐ **DAC Services** → ***Check Type:*** ☐ Medical/Rehabilitation ☐ Disability ☐ Catastrophic ☐ Attendant Care ☐ Post 104 weeks
- ☐ **Other Assessment (Section 24)** → ***Check Type:*** ☐ Treatment Plan ☐ Disability Certificate ☐ Other

Part 2 Claimant Information

Date of Birth (year / month / day)	Gender: ☐ Male ☐ Female
Last Name	
First Name	Middle Name
Address	
City	Province / Postal Code
Is there an approved Treatment Plan (OCF-18) for this claimant? ☐ Yes ☐ No ☐ Waived by Insurer	If yes, date Treatment Plan signed by health practitioner (year / month / day)

Part 3 Automobile Insurer Information

Company Name	City or Town of Branch Office (if applicable)
Adjuster Last Name	Adjuster First Name
Date of Accident (year / month / day)	Policy Number
Claim Number	
Name of policy holder: ☐ Claimant, OR	Last Name / First Name

Part 4 Other Insurance Information

Is there OHIP coverage for services billed on this invoice? ☐ Yes ☐ No ☐ Not applicable

OTHER INSURANCE: Is there other insurance coverage for the billed services listed on this invoice?
I have made reasonable enquiries of the claimant/patient and have determined that:

☐ **NO** *There is no other insurance coverage for these services*

☐ **YES** *There is other insurance coverage that is potentially available to cover/partially cover these services. The details are expressed in this section of the invoice.*

NOTE:
If this is a second or subsequent invoice, facilities do not have to fill out Part 4, unless the information has changed.

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 5 Provider Information

(use box number from this section as **Provider Reference Number** in Part 7 Service Information and in Part 9 Supplies Provided to Patient)

1	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID
2	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID
3	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID
4	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID
5	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID
6	Last Name	First Name
	Profession/occupation	College Registration Number or Provider ID

Part 6
Injury and Sequelae Information

(use box number from this section as **Injury Reference Number** in Part 7 Service Information)

NOTE:
If this is a second or subsequent invoice, facilities do not have to fill out or submit Part 6, unless the injury coding has changed, but the Injury Reference Number must be used on every invoice in Part 7.

Injury and Sequelae Pick List (ICD-10-CA Codes)

Whiplash-Associated Disorders

1 ☐	**S13.43(1)**	**WAD1** *Complaint of neck pain, stiffness or tenderness only. No physical sign(s).*
2 ☐	**S13.43(2)**	**WAD2** *Complaint of neck pain AND Musculoskeletal sign(s) including decreased range of motion and point tenderness.*
3 ☐	**S13.43(3)**	**WAD3** *Complaint of neck pain AND Neurological sign(s) including decreased or absent deep tendon reflexes, weakness and sensory deficits.*
4 ☐	**S13.43(4)**	**WAD4** *Complaint of neck pain AND Fracture or dislocation.*

Head Injuries

5 ☐	**S00**	*Superficial injury of head*
6 ☐	**S01**	*Open wound of head*
7 ☐	**S02 (s)**	*Fracture of skull*
8 ☐	**S02 (f)**	*Fracture of facial bones*
9 ☐	**S06.^0**	*Intracranial injury, without loss of consciousness*
10 ☐	**S06.^1**	*Intracranial injury, with brief loss of consciousness of less than 1 hour*
11 ☐	**S06.^2**	*Intracranial injury, with moderate loss of consciousness of 1-24 hours duration*
12 ☐	**S06.^3**	*Intracranial injury, with prolonged loss of consciousness greater than 24 hours duration with return to pre-existing level of consciousness*

Thorax and Abdomen Injuries

13 ☐	**S20**	*Superficial injury of thorax*
14 ☐	**S30.1**	*Contusion of abdominal wall*
15 ☐	**S22**	*Fracture of rib(s), sternum and thoracic spine*
16 ☐	**S27**	*Injury of other and unspecified intrathoracic organs*
17 ☐	**S23**	*Dislocation, sprain and strain of joints and ligaments of thorax*

Spine and Pelvis Injuries

18 ☐	**S30.0**	*Contusion of lower back and pelvis*
19 ☐	**S22**	*Fracture of rib(s), sternum and thoracic spine*
20 ☐	**S32**	*Fracture of lumbar spine and pelvis*
21 ☐	**S33**	*Dislocation, sprain and strain of joints and ligaments of lumbar spine and pelvis*

Upper Extremity Injuries

22 ☐	**S40**	*Superficial injury of shoulder and upper arm*
23 ☐	**S50**	*Superficial injury of forearm*
24 ☐	**S60**	*Superficial injury of wrist and hand*
25 ☐	**S61**	*Open wound of wrist and hand*
26 ☐	**S43**	*Dislocation, sprain and strain of joints and ligaments of shoulder girdle*
27 ☐	**S63**	*Dislocation, sprain and strain of joints and ligaments at wrist and hand level*
28 ☐	**S42**	*Fracture of shoulder and upper arm*
29 ☐	**S52**	*Fracture of forearm*
30 ☐	**S62**	*Fracture of navicular [scaphoid] bone of hand*

Lower Extremity Injuries

31 ☐	**S70**	*Superficial injury of hip and thigh*
32 ☐	**S80**	*Superficial injury of lower leg*
33 ☐	**S83**	*Dislocation, sprain and strain of joints and ligaments of knee*
34 ☐	**S93**	*Dislocation, sprain and strain of joints and ligaments at ankle and foot level*
35 ☐	**S72**	*Fracture of femur*
36 ☐	**S82**	*Fracture of lower leg, including ankle*
37 ☐	**S92**	*Fracture of foot, except ankle*

Diseases of the musculoskeletal system and connective tissue

38 ☐	**M54.0**	*Panniculitis affecting regions of neck and back (Inflammation in the fatty layer under the skin).*
39 ☐	**M54.1**	*Radiculopathy*
40 ☐	**M54.3**	*Sciatica*
41 ☐	**M54.4**	*Lumbago with sciatica*
42 ☐	**M54.5**	*Low back pain*
43 ☐	**M54.6**	*Pain in thoracic spine*
44 ☐	**M54.8**	*Other dorsalgia*
45 ☐	**M79.1**	*Myalgia*
46 ☐	**M99.1**	*Biomechanical lesions, not elsewhere classified, cervical region*
47 ☐	**M99.2**	*Biomechanical lesions, not elsewhere classified, thoracic region*
48 ☐	**M99.3**	*Biomechanical lesions, not elsewhere classified, lumbar reiogn*

Mental and behavioural disorders

49 ☐	**F06.9**	*Mild cognitive disorder*
50 ☐	**F07.2**	*Postconcussional syndrome*
51 ☐	**F32**	*Depressive episode*
52 ☐	**F33**	*Recurrent depressive disorder*
53 ☐	**F40.2**	*Specific (isolated) phobias*
54 ☐	**F41.0**	*Panic disorder (episodic paroxysmal anxiety)*
55 ☐	**F41.1**	*Generalized anxiety disorder*
56 ☐	**F41.2**	*Mixed anxiety and depressive disorder*
57 ☐	**F43.0**	*Acute stress reaction*
58 ☐	**F43.1**	*Post-traumatic stress disorder*
59 ☐	**F43.2**	*Adjustment disorders*
60 ☐	**F45**	*Somatoform disorders*
61 ☐	**F51.0**	*Nonorganic insomnia*
62 ☐	**F52**	*Sexual Dysfunction, not caused by organic disorder or disease*

Symptoms and signs

63 ☐	**R07**	*Pain in throat and chest*
64 ☐	**R13**	*Dysphagia*
65 ☐	**R52.2**	*Other chronic pain*
66 ☐	**R53**	*Malaise and fatigue*
67 ☐	**R47**	*Speech disturbances, not elsewhere classified*
68 ☐	**R48**	*Dyslexia and Alexia*
69 ☐	**R49**	*Voice disturbances*

Diseases of the nervous system

70 ☐	**G43**	*Migraine*
71 ☐	**G44.2**	*Tension-type headache*
72 ☐	**G44.3**	*Chronic post-traumatic headache*
73 ☐	**G82**	*Paraplegia and tetraplegia*

Factors influencing health status and contact with health services

74 ☐	**Z56**	*Problems related to employment and unemployment*
75 ☐	**Z63**	*Other problems related to primary support group, including family circumstances*
76 ☐	**Z73**	*Problems related to life-management difficulty*

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA)

ICD-10-CA is the Canadian standard for classifying diseases, injuries and causes of death, as well as external causes of injuries.

Other Injury and Sequelae Codes (ICD-10-CA)

	Injury Description	Injury Code (ICD-10-CA)
77		
78		
79		

Part 7
Service Information

(use **Provider Reference Number** from Part 5 and **Injury Reference Number** from Part 6 to complete this section)

(use box number from this section as **Service Reference Number** in Part 8 Other Charges)

Include services with no net charge to auto insurer

NOTE:
Frequently used Service Codes are listed in the User Manual available at
www.standardinvoice.on.ca

1	year / month / day Description Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
2	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
3	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
4	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
5	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
6	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
7	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
8	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
9	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
10	year / month / day Description (☐ Check here if same as above) Service Code	Provider Reference Number	Injury Reference Number(s)	Pre-authorized by Auto Insurer? ☐ Yes ☐ No	Time in minutes	Hourly Fee $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $

Subtotal Service Charges to Auto Insurer	$

If more pages are required, use Page 4a available at
www.standardinvoice.on.ca

Part 8
Other Charges

(use **Service Reference Number** from Part 7 Service Information to complete this section)

NOTE:
If there are no Other Charges being billed, this page does not have to be submitted.

1	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
2	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
3	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
4	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
5	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
6	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
7	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
8	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
9	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
10	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
11	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $
12	Service Reference Number	Other Charges ☐ Mileage ☐ Travel Time ☐ Disbursements:	Number of Km or Number of minutes	Rate per Km or per hour	Amount $	Net Charge to OHIP/Other Insurer(s) $	Net Charge to Auto Insurer $

Subtotal Other Charges to Auto Insurer	$

If more pages are required, use Page 5a available at www.standardinvoice.on.ca

Part 9
Supplies Provided to Patient

(use **Provider Reference Number** from Part 5 Provider Information to complete this section)

	Provider Reference Number	Description / Supply Code	Amount	Net Charge to OHIP/Other Insurer(s)	Net Charge to Auto Insurer
1			$	$	$
2			$	$	$
3			$	$	$

NOTE:
Supply Codes are listed in the User Manual available at
www.standardinvoice.on.ca

Subtotal Supply Charges to Auto Insurer	$

Subtotal Service Charges to Auto Insurer (Part 7)	$
Subtotal Other Charges to Auto Insurer(Part 8)	$
Subtotal Supply Charges to Auto Insurer (Part 9)	$
Total Charges to Auto Insurer (part 7 subtotal + part 8 subtotal + part 9 subtotal)	$
Goods and Services Tax (GST)	$
PST on Goods (if applicable)	$
Grand Total	$
Prior Outstanding Balance as of (year / month / day)	$

Part 10
Other Information

Attach additional sheets if necessary

Is this a Final Invoice?
☐ Yes ☐ No

Comments

☐ Additional Sheets Attached

Facility Signatory

I certify that the expenses submitted and described above are true and accurate and are required as a direct result of the accident.

Print Name	Signature