Treatment Plan (OCF-18)

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

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

For this applicant, this is Treatment Plan number _____ from this health professional/facility

To the Applicant:
Please complete Parts 1 and 2. After your health professional or practitioner has reviewed your Treatment Plan with you, sign Part 13.

Your health professional/practitioner will complete all other parts of the form. **A health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 5.**

Please provide all information requested.

Collection, use and disclosure of this information is subject to all applicable privacy legislation.

To the Health Professional/Facility:

To the extent possible, this Treatment Plan should include all goods and services contemplated by this health professional/facility for the period of this Treatment Plan. **Consent:** it is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities should use the Ontario Claims Form 5 (OCF – 5) *Permission to Disclose Health Information* as a consent form.

Note: If this is an impairment that comes within a PAF Guideline, you are required to complete an OCF – 23/198 Pre-approved Framework Treatment Confirmation Form instead of this Treatment Plan Form unless application is being made for additional goods or services not provided under a PAF Guideline.

Part 1 Applicant Information

To be completed by the applicant

Date Of Birth (YYYYMMDD)	Gender ❑ Male ❑ Female	Telephone Number
Last Name		
First Name	Middle Name	
Address		
City	Province	Postal Code —

Part 2 Insurance Company Information

To be completed 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 health professional responsible for plan preparation and supervision with information from the applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment 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 Treatment 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 Conflict of Interest Definition

A person has a conflict of interest relating to a Treatment Plan if,

i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and

ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Note: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

Part 5 Signature of Health Practitioner

Plan Certification

Name of Health Practitioner		College Registration Number
Facility Name (if applicable)		AISI Facility Number (if applicable)
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

❑ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, ***and*** I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.

or

❑ I am declaring the following conflicts of interest relating to this Treatment Plan:

I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7.

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 6 Signature of Regulated Health Professional

Plan Preparation and Supervision

If same person as Part 5 check here ❑ and ***DO NOT COMPLETE Part 6***

Name of Regulated Health Professional		Registration Number
Facility Name (if applicable)		AISI Number (if applicable)
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
- ❑ Other_____

❑ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, ***and*** I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.

or

❑ I am declaring the following conflicts of interest relating to this Treatment Plan:

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 Health Professional:
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 7 Injury and Sequela Information

Provide a description (list most significant first) and associated ICD-10-CA+ code for injuries and sequelae that are the direct result of the automobile accident.

Description	Code

Note : Refer to the User manual at www.autoinsurancereforms.on.ca for ICD-10-CA coding information.

Part 8 Prior and Concurrent Conditions

❑ Additional Sheet Attached

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 7?
❑ 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 7?
❑ No ❑ Unknown ❑ Yes (please explain)

c)
Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline?
❑ Yes ❑ No
If yes, please provide a complete explanation, in accordance with the PAF Guidelines, and with express reference to the provisions of the PAF Guidelines on which you rely, why this OCF-18 Treatment Plan is being submitted instead of a Pre-approved Framework Treatment Confirmation Form (OCF-23/198).

❑ additional sheets attached

Part 9 Activity Limitations

a) Does the applicant's impairment(s) from the injuries identified in Part 7 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 10 Treatment 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 Plan seeks to achieve:

- ❑ pain reduction
- ❑ increase in strength
- ❑ increased range of motion
- ❑ other(s) (please specify)

and

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

- ❑ return to activities of normal living
- ❑ return to modified work activities
- ❑ return to pre-accident work activities
- ❑ other(s) (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 Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

❑ additional sheets attached

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, that is not included in this Treatment Plan, will be provided by any other provider/facility?

❑ No ❑ Yes (please explain)

e) Consistency:

Are there any utilization guidelines applicable to the proposed treatment?

- ❑ Yes (Identify guideline):
- ❑ No (Please explain):

Applicant Name:		INSURER FAX BACK	Claim Number:	
Policy Number:			Date of Accident:	

Part 11 Health Providers

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

Part 12 Proposed Goods and Services

To the extent possible, this Treatment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility for the period of this Treatment Plan

G/S Ref	Description	Code	Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	Measure	Cost	Total Count	Total Cost
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

Estimated duration of this Treatment Plan:	**weeks**	**Sub-Total:**	
How many treatment visits have you already provided:	**visits**	**- Minus MOH:**	
		- Minus Other Insurer 1 + 2:	
		GST (if applicable):	
		PST (if applicable):	
		Auto Insurer Total:	

Note : Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.
Attributes codes are used to further qualify the service codes and are described in the manual.

Note -: Payment by auto insurer is secondary to available collateral benefits.

Please indicate any additional comments regarding proposed goods and services:

❑ additional sheets attached

Part 13 Signature of Insurer

❑ I waive the requirement of the Applicant's signature.

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

❑ Approve this Treatment Plan ❑ Partially approve (explanation attached) ❑ Do not approve (explanation attached)

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 14 days of receiving the completed application (within 5 business days if the insurer rejects the Treatment Plan on the basis that a PAF Guideline applies) give the applicant notice of their decision on the Treatment Plan.

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 5 and the Regulated Health Professional, if applicable, indicated in Part 6.

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 Health Practitioner will contact each of the health professionals listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.

Part 14 Signature of Applicant

Must be completed unless waived by insurer

I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer.
In the event that the Treatment Plan is disputed by my insurer I understand that I will have 5 business days to respond in writing if I wish to withdraw this Treatment Plan. If I wish to proceed, a Designated Assessment Centre shall be selected in the manner set out in the Statutory Accident Benefits Schedule. Once a Designated Assessment Centre has been selected, the insurer has 5 business days to arrange for the assessment.

I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, and treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.

I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.

Subject to the Statutory Accident Benefits Schedule, I understand that, if I undertake any of the proposed treatments prior to the approval of this Treatment Plan by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.

TO THE INSURER:

I UNDERSTAND that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of my accident described in my application.

I ALSO UNDERSTAND that this information will be collected, used and disclosed for the purposes of:

- Investigating and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Identifying and analyzing the nature, effects and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing and detecting fraud;
- Compiling anonymized statistics for government agencies;
- Assessing underwriting risks and claims experience; and
- Allowing you to comply with your legal obligations to others, such as government regulators, auditors and reinsurers.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information for the purposes described above:

- Insurers; reinsurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; federal, provincial or municipal governments and agencies where required or authorized by law; police forces or law enforcement agencies; and my agents or representatives;
- Organizations designated as investigative bodies under privacy laws;
- Claims processing agencies and statistical analysis organizations to whom you are directed by law to disclose claims, payment requests and other claims information; and
- Organizations that consolidate claims and underwriting information for the insurance industry.

I CONSENT to you collecting, using and disclosing this information in the manner described above.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)