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 or social worker**

To the Applicant:
Please complete Parts 1 and 2. After your health professional or practitioner or social worker has reviewed your Treatment Plan with you, sign Part 14.

Your health professional/practitioner or social worker 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.

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**

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

To the Health Professional/Facility or Social Worker:
To the extent possible, this Treatment Plan should include all goods and services contemplated by this health professional/facility or social worker for the period of this Treatment Plan.

Consent: It is the responsibility of the health professional/facility or social worker to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities or social workers can 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 or social worker 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 or social worker 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 or Social Worker

Plan Preparation and Supervision If same person as Part 5 check here ☐ and ***DO NOT COMPLETE Part 6***

Name of Regulated Health Professional or Social Worker		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
- ☐ Social Worker
- ☐ 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/Social Worker (please print)	Signature of Regulated Health Professional/Social Worker	Date (YYYYMMDD)

To the Health Professional or Social Worker:
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.hcaiinfo.ca for ICD-10-CA coding information.

Part 8 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 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).

Send any attachments directly to the insurer

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?

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, 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**		**Policy Number:**	
Provider Name:				**Claim Number:**	
Provider Fax:				**Date of Accident:**	

Part 11 Health Providers/ Social Workers

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 or Social Worker 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									

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.hcaiinfo.ca for coding.

Attributes codes are used to further qualify the service codes and are described in the manual.

Payment by auto insurer is secondary to available collateral benefits.

*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 Plan and based upon the information provided, I:

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

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 10 business 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 a notice:

1. Stating the goods and services contemplated by the treatment plan the insurer will pay for; or
2. Advising the applicant that an examination is required for any goods or services that the insurer has not agreed to pay for; or
3. Stating that an examination is required to determine if a Pre-approved Framework Guideline applies.

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 or Social Worker, 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 my insurer does not agree to pay for all the goods and services contemplated in this treatment plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment Plan.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly 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 by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination 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.

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination (referred to in sections 24(1) 9 and 24.1(1) 2 of the Statutory Accident Benefits Schedule – On or After November 1, 1996). Separate express consent is required for this consultation. This consent should be in writing.

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)