Auto Insurance Standard Invoice (OCF-21)

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

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

Attach Version C - pages 2 and 3 for Pre-approved Frameworks (PAFs). 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.

Confidentiality: Collection, use and disclosure of this information is 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**

Part 1 Applicant Information

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

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 Invoice Information

*Invoice Number	
First Invoice	☐ Yes ☐ No
Last Invoice	☐ Yes ☐ No

For **previously approved goods and services**, please complete the following:

*Type of Plan or Pre-approved Framework	*Plan Date (YYYYMMDD)	*Plan Number	*Approved Amount	*Previously Billed
☐ Treatment Plan (OCF-18) ♦				
☐ Assessment Plan (OCF-22) ♦				
☐ PAF Type: ♣				

♦ Attach Version A or B
♣ Attach Version C

For all other Invoices, attach Version B

Part 4 Payee Information

Facility Name (if applicable)	AISI Facility Number (if applicable)	
Payee Last Name	Payee First Name	Payee Number (if applicable)
Address		
City / Province		Postal Code
Telephone Number - - Extension	*Fax Number - -	
*Email Address		

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

Or

☐ I am declaring the following conflicts of interest relating to this invoice:

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. This information will be used for processing payments of claims; identifying and analysing the nature and costs of goods and services that are provided to automobile accident victims, by health care providers; preventing fraud and detecting fraud where there are reasonable grounds to suspect fraud.

Name of Health Professional Social Worker or Authorized Signatory (please print)	Signature of Health Professional Social Worker or Authorized Signatory	Date (YYYYMMDD)

OCF-21 - Version A - page 2

This form may be used for billing goods and services that have been previously approved by the insurer through an OCF-18 or OCF-22.
This form may not be used for Pre-approved Frameworks (use Version C - pages 2 and 3) or goods and services that have not been previously approved (use Version B - pages 2 and 3).

Injuries and Sequelae	
Description	**†Code**

Injury details are not required if they are the same as those on an approved plan.
† Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers				Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	**†Type**	**Last Name**	**First Name**				
A							
B							
C							
D							
E							
F							

Provider details are not required if they are the same as those on an approved plan.
† Refer to the User Manual at www.hcaiinfo.ca for coding.

†G/S Ref	Month (yyyy-mm): 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	PST	GST	Cost/ Day	Total Count	Total Cost

† Refer to the previously approved plan for each good and service reference number (G/S Ref).
Enter the Provider Reference from the previously approved plan or the Provider table above at the intersection of the date of service and the G/S Ref indicating the provider who rendered or prescribed the service or good.

Other Insurance (for goods and services on this invoice)

	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)

Prior Balance:	
Payment Received from Auto Insurer:	
[2]Overdue Amount:	

[2]The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.

Sub-Total:	
MOH:	
Other Insurer 1 + 2:	
GST *(if applicable)*:	
PST *(if applicable)*:	
[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:

Send any attachments directly to insurer

OCF-21 - Version B - page 2

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 or OCF-22.
They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

Injuries and Sequelae

Description	†Code

Injury details are not required if they are the same as those on a previously approved plan.
†Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers

Ref	†Type	Last Name	First Name	Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
A							
B							
C							
D							
E							
F							

Provider details are not required if they are the same as those on a previously approved plan.
† Refer to the User Manual at www.hcaiinfo.caca for coding.

Date of Service			Description	†Code	†Attribute	Provider Reference	Quantity	†Measure	GST (✔)	PST (✔)	Cost
YYYY	MM	DD									
† Refer to the User Manual at www.hcaiinfo.ca for coding.							**Sub-Total**				

Send any attachments directly to insurer

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 or OCF-22.
They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (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? ☐ 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

Other Insurance details are not required if they are the same as those on a pre-approved plan.

Conflict of Interest Definition

A person has a conflict of interest relating to an invoice if:

i. The person or a related person or another person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person, of the goods or services, 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.

Other Insurance (for goods and services on this invoice)

	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)

*Prior Balance:	
*Payment Received from Auto Insurer:	
[2]Overdue Amount:	

[2]The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.

Sub-Total:	
MOH:	
Other Insurer 1 + 2:	
GST *(if applicable)*:	
PST *(if applicable)*:	
[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 2

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework.
For all other goods and services attach Version A or B.

Injuries and Sequelae	
Description	**†Code**

Injury details are not required if they are the same as those on the Pre-approved Framework Treatment Confirmation Form (OCF-23/198)
†Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers				Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	*Hourly Rate	For Insurer's Use
Ref	**†Type**	**Last Name**	**First Name**				
A							
B							
C							
D							
E							
F							

† Refer to the User Manual at www.hcaiinfo.ca for coding.

Goods and Services Rendered (PAF providers are required to declare the information requested below on every treatment, service and good delivered. Failure to provide this information may delay payment)

Date of Service			Description	†Code	†Attribute	Provider Reference	Quantity	†Measure
YYYY	MM	DD						

† Refer to the User Manual at www.hcaiinfo.ca for coding.

Send any attachments directly to insurer

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 guidelines of a Pre-approved Framework.
For all other goods and services attach Version A or B.

Reimbursable Fees Within the PAF Guidelines:

Description	†Code	†Attribute	Cost
†Refer to the User Manual at www.hcaiinfo.ca for coding.		**PAF Fee Totals:**	

Other Reimbursable Goods and Services Approved by the Insurer:

Date of Service YYYY	Date of Service MM	Date of Service DD	Description	†Code	†Attribute	Provider Reference	Quantity	†Measure	GST (✔)	PST (✔)	Cost
†Refer to the User Manual at www.hcaiinfo.ca for coding.								**Other Goods and Services Total:**			

Other Insurance (for goods and services on this invoice)

	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)

Prior Balance:	
Payment Received from Auto Insurer:	
[2]Overdue Amount:	

[2]The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.

Sub-Total:	
MOH:	
Other Insurer 1 + 2:	
GST *(if applicable)*:	
PST *(if applicable)*:	
[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