Designated Assessment Centre Referral, Plan, and Summary Form (OCF-11)

Use this form for accidents that occur on or after January 1, 1994.

Claim Number:	
Policy Number:	
Date of Accident:	

Section 1: Identification of Parties

Part 1 Applicant Information
To be completed by the insurer

Date Of Birth (YYYYMMDD)	Age	Gender ❑ Male ❑ Female	Telephone Number
Last Name	First Name	Middle Name	
Address			
City	Province	Postal Code	
Special Needs (if applicable) ❑ Mobility ❑ Interpreter (type) ❑ Other (specify)			
Representative (if applicable)	Address		
Telephone Number	Fax Number	Email	

Part 2 Insurance Information
To be completed by the insurer

Insurance Company Name	City or Town of Branch Office (if applicable)	
Address		
City	Province	Postal Code
Supervisor Last Name	Supervisor First Name	
Adjuster Last Name	Adjuster First Name	
Telephone Number	Fax Number	Email

Part 3 Designated Assessment Centre (DAC) Information
To be completed by the insurer

Facility Name		DAC Number
Address		
City	Province	Postal Code
Contact Last Name	Contact First Name	
Telephone Number	Fax Number	Email

Part 4 Insurer Signature

❑ I certify that this referral is being made to a DAC that was jointly selected with the applicant; or
❑ I certify that this referral is being made to a DAC selected by the Financial Services Commission of Ontario in accordance with procedures established by the Superintendent of Financial Services (see attached notification).

I certify that I have included all relevant information necessary for the assessment.

Name of Insurance Company Representative (please print)	Signature of Insurance Company Representative	Date (YYYYMMDD)

Section 2: Summary of Disputed Issues (To be completed by the insurer)

Part 5 - Disputed Benefit	Description of Dispute	Date of Denial
Income Replacement Benefits ❑ Employed ❑ Unemployed ❑ Future Employment ❑ Post-104 Disability		
❑ Non-Earner Benefits		
❑ Caregiver Benefits		
❑ Education Disability Benefits (Bill 164)		
❑ Other Disability Benefits (Bill 164)		
❑ Residual Earning Capacity (Bill 164)		Date of Offer

Part 6 - Medical and Rehabilitation Assessments

Part 6A - Dispute Relating to an Application for Approval of an Examination or Assessment

Dispute Ref	Description of Dispute
6A ❑	

Part 6B - Dispute Relating to a Pre - approved Framework Guideline

Dispute Ref	Description of Dispute
6B ❑	

Part 6C - Dispute Relating to a Treatment Plan (OCF 18)

(Attach additional pages for each Treatment Plan in dispute, if required)

Date of Disputed Treatment Plan: / /

Dispute Regarding Reasonableness and Necessity of Proposed Goods and Services

Dispute Ref	Information from treatment plan				Nature of Dispute (please ✔ appropriate boxes)						
G/S Ref	Provider Type	Description	Code	Attribute	Estimate / Day			Duration	Total Cost	All	Concurrent treatment
					Quantity	†Measure	Cost				
1											
2											
3											
4											
5											

In addition to the dispute regarding goods and services described above, indicate below any associated dispute(s) regarding injury diagnosis, status of impairment(s) or causality.

Dispute Ref	Injury/Impairment information from treatment plan		Nature of Dispute (please ✔ appropriate boxes)		
(See OCF 18 Part 7)	Description	Code	Impairment Description/Diagnosis	Status	Causality
6C6 ❑					
6C7 ❑					
6C8 ❑					

Part 7 - Attendant Care Assessment

Dispute Ref	Date of Form 1 (yyyymmdd)	Amount in Dispute	Description of Dispute
7			

Part 8 - Catastrophic Impairment Assessment

Dispute Ref	Date of Application (yyyymmdd)	Categories	Description of Dispute
8			

Section 3:Documents

Part 9 - Documents from Insurer (To be completed by the insurer)

List and attach documents forming the referral package (For example: medical reports, clinical notes and records, surveillance video tapes, and test results)

Date of Document (yyyymmdd)	Author	Description	Date Sent to DAC (To be completed by insurer or DAC)	Date Received by the DAC (To be completed by DAC)

❑ Additional Sheets Attached

Part 10 - Documents from Applicant

It is the applicant's responsibility upon receiving a copy of this form from their insurer, to advise the Designated Assessment Centre of any other documents not listed above which may be useful in completing the assessment.

Date of Document (yyyymmdd)	Author	Description	Date sent to DAC (To be completed by Applicant)	Date Received by the DAC (To be completed by DAC)

❑ Additional Sheets Attached

Part 11 - Documents Requested by DAC

Date of Document (yyyymmdd)	Author	Description	Date Requested by DAC (To be completed by DAC)	Date Received by the DAC (To be completed by DAC)

Section 4: DAC Assessment Plan

To be faxed to Insurance Company and sent to applicant when appropriate.

Claim Number:	
Policy Number:	
Date of Accident:	

Part 12 Designated Assessment Centre Information

To be completed by the insurer

Facility Name		DAC Number
Contact Last Name	Contact First Name	
Telephone Number	Fax Number	Email

Part 13 Proposed Assessment Team

Assessor Ref	†Assessor Type	Assessor Ref	†Assessor Type
A		D	
B		E	
C		F	

Other Services

Service Ref	†Service	Company	Hourly Rate
X			
Y			
Z			

Part 14 - Itemized Goods and Services

G/S Ref	Description	†Code	Dispute Ref(s)	Assessor/ Service Ref	Estimated		
					Quantity	†Measure	Total Cost
1							
2							
3							
4							
5							
6							
7							
						Sub-Total:	
						GST (if applicable):	
						PST (if applicable):	
						Total Estimated Cost:	

The assessment is a staged, focussed process. Assessments are listed in the order of anticipated completion that will allow the assessment team to formulate an opinion to address the dispute.

Note †: **Refer to User Manual coding guidelines which may be found at : www.autoinsurancereforms.on.ca**

Part 15 Signature of Coordinating Health Professional

Please provide a copy of this page to the Applicant

Conflict of Interest: I have reviewed the referral package and am prepared to declare that:

❑ There is no conflict of interest with respect to this referral

❑ We have a conflict of interest with respect to this referral. Nature of Conflict of Interest: _____

Time Lines: Assessment can be completed within the required time lines:

❑ Yes ❑ No If not, date of first available appointment:

I confirm that this proposed DAC assessment plan conforms to established DAC assessment guidelines. Any changes to this assessment proposal will be communicated to both parties as soon as the need for such changes becomes evident.

Name of Coordinating Health Professional (please print)	Signature of Coordinating Health Professional	Date (YYYYMMDD)

Part 16 Signature of Insurer

Please return a copy of this page to the Coordinating Health Professional

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

❑ the insurer and the applicant have agreed to waive declared conflict ❑ the insurer approves this Assessment Plan ❑ the insurer does not approve this Assessment Plan

I authorize that the above summary appropriately reflects the issues in dispute and the DAC may proceed with the above proposed assessment plan in accordance with DAC assessment guidelines

Name of Insurance Company Representative (please print)	Signature of Insurance Company Representative	Date (YYYYMMDD)

Section 5: DAC Assessment Report

For Fast-track Assessments

To be faxed to Insurance Company and sent to applicant and applicant's health practitioner

Claim Number:	
Policy Number:	
Date of Accident:	

Part 17A – FAST TRACK DAC Assessment Findings

- ❑ **Disputes Regarding Application for Approval of Examination or Assessments**
- ❑ **Pre-approved Framework Disputes**

Summary of Assessment Findings:

Part 18 Signature of Coordinating Health Professional

The opinions with respect to the disputed issues as stated above have been reached as a result of the completion of the investigations as outlined in the assessment plan and have been reached in accordance with DAC assessment guidelines.

Name of Clinical Coordinator (please print)	Signature of Clinical Coordinator	Date (YYYYMMDD)

Section 6: DAC Assessment Summary

For assessments other than Fast-Track assessments
To be faxed to Insurance Company and sent to applicant and applicant's health practitioner

Claim Number:	
Policy Number:	
Date of Accident:	

- ❑ **Disability Assessment**
- ❑ **Medical and Rehabilitation Assessment**
- ❑ **Attendant Care Assessment**
- ❑ **Catastrophic Impairment Assessment**

Summary of Assessment Findings:

Part 18 Signature of Coordinating Health Professional

The opinions with respect to the disputed issues as stated above have been reached as a result of the completion of the investigations as outlined in the assessment plan and have been reached in accordance with DAC assessment guidelines.

Name of Clinical Coordinator (please print)	Signature of Clinical Coordinator	Date (YYYYMMDD)