Pre-approved Framework Extension Request & Discharge Report (OCF-24/198)

Use this form for accidents that occur on or after October 1, 2003

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

To the Health Practitioner/Facility Consent: It is the responsibility of the health practitioner/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health practitioners /facilities should use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed. Collection, use and disclosure of this information are subject to applicable privacy legislation.

This form is to be used in accordance with the Pre-approved Framework Guidelines to request approval for an extension of PAF services from the insurer OR to discharge the insured person from the PAF.

Part 1 Purpose of the OCF-24

This OCF-24 is being submitted to (check one):

☐ Request an extension of PAF services from the insurer (complete Parts 2, 3 and 4 below)

☐ Discharge the insured person from the PAF (complete Parts 2, 3, 4, 6, and 7 below)

Part 2 Insured Person Information

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

Part 3 Insurance Company Information

Company Name	City or Town of Branch Office (if applicable)
Adjuster's Last Name	Adjuster's First Name
Adjuster's Telephone Number Extension	Adjuster's Fax Number
Is the Policy Holder the Insured Person? ☐ Yes ☐ No	If No, specify : Policy Holder's Name

Part 4 Health Practitioner Information and Signature

Name of Health Practitioner (please print)	College Registration Number	Type of Health Practitioner ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)	AISI Facility Number (if applicable)	
Address		
City / Province / Postal Code		
Telephone Number Extension	Fax Number	
Email Address		

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 analyzing 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.

Signature of Health Practitioner	Date (YYYYMMDD)

Part 5 Approval for PAF Extension

To be completed by the Insurance Adjuster and faxed back to the Health Practitioner (check one):

☐ Extension of PAF services is approved

☐ Extension of PAF services is not approved (please explain reason)

Name of Adjuster	Signature of Adjuster	Date (YYYYMMDD)

Part 6 Insured Person's Discharge Status

Indicate the insured person's status at the time of discharge from the PAF (check one).

☐ No additional intervention required.

☐ Additional intervention outside of the PAF is required. If checked, specify one of following:

- ☐ Intervention outside the PAF Guideline is being proposed through submission of a treatment plan (OCF-18)
- ☐ The insured person has been referred to another health professional. If checked, specify the type of health professional to whom the insured person has been referred and the name and address of the health professional, if available

☐ The insured person was discharged because he/she was non-compliant, was not attending sessions or voluntarily withdrew from the PAF.

Part 7 Insured Person's Functional Status at Discharge

Indicate the insured person's functional status at the time of discharge from the PAF (check all that apply)

☐ The insured person was employed at the time of the accident.

If checked, did the insured person lose time from work as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person returning to work at discharge? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person was a care-giver at the time of the accident.

If checked, did the insured person lose time from care-giving as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person returning to care-giving activities at discharge? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person was neither employed nor a care-giver at the time of the accident.

If checked, did the insured person have difficulty performing regular activities as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person returning to regular activities at discharge? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person had difficulties performing housekeeping activities as a result of the accident.

If checked, did the insured person receive housekeeping assistance? ☐ Yes ☐ No

If yes, does the insured person still require housekeeping assistance following discharge? ☐ Yes ☐ No

Provide additional information regarding the insured person's functional status, as necessary