Application for Approval of an Assessment or Examination (OCF-22)

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

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

To the Applicant:

Use this form to request prior approval for payment of an assessment or examination fee for which prior approval is required.

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

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**

To the Health Professional/Facility or Social Worker:

Consent: It is the responsibility of the health professional/facility or social worker to ensure that their collection, use and disclosure of information submitted is 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.

A submission for insurer approval/payment of an expense for an assessment or examination may be made either with this form or a Treatment Plan (OCF-18) form.

Part 1 Applicant Information

To be completed by the applicant

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

To be completed by the applicant

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 Signature of Regulated Health Professional or Social Worker

Name of Regulated Health Professional/Social Worker	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
- ☐ Massage Therapist
- ☐ Nurse Practitioner
- ☐ 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 form and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form,

or

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

I confirm that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.

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

Part 4 Nature of Assessment or Examination

Except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline, payment for all assessments and examinations is dependent upon approval by the insurer or if disputed by an arbitration or by the courts. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please ✓ the appropriate box in the chart below to indicate what situation applies to this application.

***PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING :**

- ☐ an assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;
- ☐ not more than three assessments or examinations if:
  - the cost of each assessment or examination does not exceed $200.00, and
  - not more than one assessment or examination is done by the same person;
- ☐ an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS.

***PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR:**

- ☐ all other assessments or examinations to complete Treatment Plans, not outlined above.

***PRIOR APPROVAL MAY BE REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE DISABILITY CERTIFICATES:**

- ☐ prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment for the certificate does not exceed $200.00;
- ☐ prior approval is required for assessments to complete disability certificates that exceed $200.00.

***PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO PREPARE A FORM 1:**

- ☐ prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1.

***PRIOR APPROVAL MAY BE REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO DETERMINE CATASTROPHIC IMPAIRMENT:**

- ☐ prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is hospitalized or in a long-term care facility at the time of the assessment or examination;
- ☐ prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination.

***ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL:**

- ☐ prior approval is required for all other assessments not outlined.

Part 5 Provisional Clinical Information

a) Clinical Information:

i. Provide a brief description of the present complaints.

ii. Has the applicant already been provided treatment under your care? ☐ No ☐ Yes

b) Assessment Information:

i. Describe the details of the assessment requested and the rationale for it.
- If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment.
- For multi-disciplinary assessments, include the detail and rationale for each component of the assessment.

ii. After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant? ☐ No ☐ Yes

If yes, provide date if possible (YYYYMMDD)

Applicant Name:		OCF-22 - FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 6 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 7 Proposed Goods and Services

This Assessment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility.

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimated		
					Quantity	†Measure	Total Cost
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

Note: † Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca.
Attribute 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.

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

Are there any attachments? ☐ **Yes** ☐ **No** **If yes, how many?** _______
Send any attachments directly to the insurer

Part 8 Signature of Insurer

☐ ***I waive the requirement for the applicant's signature on a OCF 18 Treatment Plan.

I have reviewed this form and based upon the information provided, I

☐ Approve ☐ Partially approve ☐ Do not approve

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 3 business days of receiving the completed form for proposed assessments:

1. Give the health professional or social worker and the applicant a notice approving the assessment or
2. Advise the applicant that the insurer is not agreeing to pay part or all assessments and advising the applicant that an examination is required.

Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.

Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This should be billed to the insurer directly.

Part 9 Signature of Applicant ***
(Optional)
If not completed, the Health Professional or Social Worker in Part 3 assumes responsibility for obtaining applicant's consent

I have reviewed and confirm the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer. In the event that my insurer seeks a further review of the application, my insurance company may require that I be examined by a health professional, social worker, or vocational rehabilitation expert identified by the insurer to review the application.

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)