

Auto Insurance Standard Invoice (OCF-21)

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

****Claim Number:**

****Policy Number:**

Date of Accident:
(YYYYMMDD)

To be used 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.

Confidentiality: Collection, use and disclosure of this information are 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

Attach Version C - pages 2 and 3 for Minor Injury Guideline for accidents that occurred on or after September 1, 2010 or Pre-Approved Framework (PAF) treatments for accidents that occurred prior to September 1, 2010.

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.

Part 1 Applicant Information	Date Of Birth (YYYYMMDD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Applicant OR			**Policy Holder Last Name		*Policy Holder First Name		

Part 3 Invoice Information	Invoice Number		First Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No	
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For previously approved goods and services, please complete the following:					
*Type of Plan or Minor Injury Guideline or Pre-approved Framework Treatments		*Plan Date (YYYYMMDD)	*Plan Number	*Approved Amount	*Previously Billed
<input type="checkbox"/> Treatment and Assessment Plan (OCF-18) ♦					
<input type="checkbox"/> Minor Injury Guideline or PAF	Type: *				
♦ Attach Version A or B			For all other Invoices, attach Version B		
♣ Attach Version C					

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 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 Provider or Authorized Signatory (please print)		Signature of Provider or Authorized Signatory		Date (YYYYMMDD)

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.

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

Injuries and Sequelae		Providers				Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Description	Code	Ref	Type	Last Name	First Name				
		A							
		B							
		C							
		D							
		E							
		F							
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.		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.ca for coding.							

Date of Service			Description	Code	Attribute	Provider Reference	Quantity	Measure	Tax (✓)	Cost
YYYY	MM	DD								
							Sub-Total			

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

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. They may be used, at the discretion of the provider, for billing any goods or services except Minor Injury Guideline or Pre-approved Framework Treatments (use Version C - pages 2 and 3).

OTHER INSURANCE: I have made reasonable enquiries of the claimant and have determined that:		
<input type="checkbox"/> NO <i>There is no other insurance coverage identified for these goods and services</i> <input type="checkbox"/> YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>		
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for goods and services included in this invoice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.		

Other Insurance (for goods and services on this invoice)	MOH	Insurer 1	Insurer 2	Account Activity since Last Invoice (if interest is being charged)	Sub-Total:
	Chiropractic:				MOH:
	Physiotherapy:			*Prior Balance:	Other Insurer 1 + 2:
	Massage Therapy:			*Payment Received from Auto Insurer:	Tax (if applicable):
	¹ Other Service Type:				
	Total:			² Overdue Amount:	² Interest:
	¹ Please Specify Other Service Type:			⁴ The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.	Auto Insurer Total:

Make cheque payable to:	
***Other Information:	
Are there any attachments? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Minor Injury Guideline or Pre-approved Framework Treatments.
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 Treatment Confirmation Form (OCF-23) †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 (Minor Injury Guideline or Pre-approved Framework Treatments, 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.

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 Minor Injury Guideline or Pre-approved Framework.
For all other goods and services attach Version A or B.

Reimbursable Fees Within the Minor Injury Guideline or Pre-Approved Framework:			
Description	'Code	'Attribute	Cost
*Refer to the User Manual at www.hcaiinfo.ca for coding.			Minor Injury Guideline or Pre-approved Framework Fee Totals:

Other Reimbursable Goods and Services Approved by the Insurer:										
Date of Service			Description	'Code	'Attribute	Provider Reference	Quantity	'Measure	Tax (✓)	Cost
YYYY	MM	DD								
* 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	Account Activity since Last Invoice (if interest is being charged)		Sub-Total:	
	Chiropractic:						MOH:
	Physiotherapy:				Prior Balance:		Other Insurer 1 + 2:
	Massage Therapy:				Payment Received from Auto Insurer:		Tax (if applicable):
	¹ Other Service Type:				² Overdue Amount:		²Interest:
	Total:						Auto Insurer Total:
¹ Please Specify Other Service Type:				² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.			

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	Grand Total