# 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.

Please provide all information requested.

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.

**To the Health Professional/Facility:**

**Consent:** It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted is authorized by a consent form. Health professionals/facilities should 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

| | | |
|---|---|---|
| Name of Regulated Health Professional | | 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
- ❑ 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 certify 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 (please print) | Signature of Regulated Health Professional | Date (YYYYMMDD) |

**Part 4 Nature of Assessment or Examination**

Payment for all assessments and examinations is dependent upon approval by the insurer or, if disputed, by a DAC except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline. 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 insured person has not received treatment under a *Pre-approved Framework Guideline*,
  - the cost of each assessment or examination does not exceed $180.00, and
  - not more than one assessment or examination is done by the same person;
- ❑ not more than one assessment or examination if:
  - the insured person has received treatment under a *Pre-approved Framework Guideline*,
  - the cost of the assessment or examination does not exceed $180.00, and
  - the person conducting the assessment or examination did not provide goods or services under a Pre-approved *Framework Guideline* in respect of the same accident;
- ❑ 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;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

**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.

**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 $180.00;
- ❑ prior approval is required for assessments to complete disability certificates that exceed $180.00;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

**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, but not an assessment or examination relating to an impairment that comes within a *Pre-approved Framework Guideline* unless the *Pre-approved Framework Guideline* expressly states that the prior approval of the insurer is not required for the assessment or examination;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

**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;
- ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

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

- ❑ All other assessments not outlined above require prior approval.

## 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.

iii) 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 | | | | | | | |

**Note †:** Refer to the User Manual coding guidelines posted at www.autoinsurancereforms.on.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:** | |

## Part 8 Signature of Applicant

**(Optional)**
If not completed, the Health Professional in Part 3 assumes responsibility for obtaining applicant's consent

I have reviewed and confirm that 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, or if disputed by the insurer, a Designated Assessment Centre. In the event that my insurer disputes the application, I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.
I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.
Subject to the Statutory Accident Benefits Schedule, in those instances where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.

| Name of Applicant or Substitute Decision Maker (please print) | Signature of Applicant or Substitute Decision Maker | Date (YYYYMMDD) |
|---|---|---|
| | | |

## Part 9 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 (explanation to follow or attached) ❑ Do not approve (explanation to follow or attached)

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 2 business days of receiving the completed form for proposed assessments of $180.00 or less, and within 5 business days when the cost of the proposed assessment is over $180.00:

1. Give the health professional and the applicant notice of the decision.
2. If disputing the application refer the dispute to a Designated Assessment Centre.

**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 fee should be billed to the insurer directly.