



Health Claims for Auto Insurance

OCF-23

Minor Injury Guideline

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# Chapter 1:

## Create an OCF-23 & Tab 1

An OCF-23 is used for patients with injuries that are suitable for treatment in the Minor Injury Guideline (MIG). To learn which patients are eligible for treatment under the MIG, refer to the [Statutory Accident Benefits Schedule \(SABS\)](#), Section 3 (Definitions and Interpretation).

### To Create an OCF-23:


- Login to HCAI at [www.hcai.ca](http://www.hcai.ca)
- The default home screen is the Plans global tab and the Work in Progress sub-tab.


At the top of the page, select OCF-23 from the dropdown list and click **CREATE NEW**. A blank OCF-23 will open.

Use the drop-down menu to select OCF-23 and click on "Create New".

OCF Type	Patient	Status	Date Submitted
Form 1	Fox	Submitted	2016/07/28
OCF23	Mill	Review Required	2016/06/10
OCF18	Beck	Review Required	2016/06/10

## OCF-23 TABS

The OCF-23 in HCAI is organized under four tabs. These tabs reflect the parts of the paper OCF-23 form and include similar sections. To navigate between the tabs, simply click on the number along the top or bottom of the screen, or use the  button located beside the tabs.

Once you have begun working on your OCF-23, you can click the  button at any point to ensure your progress so far is saved. This will create a draft version of the OCF-23, which will appear on the Plans global tab and the Draft sub-tab. Working off a recently created draft can save steps when creating new OCF-23s.



**Do not use draft OCFs older than one year to create a new plan or invoice.**

Old versions of OCF forms are not compatible with the HCAI system and using old drafts will cause submission errors. Be sure to delete drafts older than one year in HCAI.



### Tab 1

- Claim Identifier
- Plan Identifier
- Part 1 – Applicant/Patient Information
- Part 2 – Auto Insurer Information
- Part 3 – Other Insurer Information

### Tab 2

- Part 4 – Signature of Health Practitioner
- Part 5 – Injury and Sequelae Information
- Part 6 – Prior and Concurrent Conditions
- Part 7 – Barriers to Recovery

### **Tab 3**

- Part 8 – Direct Payment Assignment
- Part 9 – Signature of the Applicant
- Part 10 – Guideline Services
- Part 11 – Other Goods and Services within the Guideline Requiring Insurer Approval

### **Tab 4**

- Additional Comments and/or Attachments

### **Claim Identifier**

- All fields marked with an asterisk are mandatory.
- Enter Claim Number and/or Policy Number
  - The Applicant/Patient must provide the Claim Number (if known) and their Policy Number.
  - The Claim Number and Policy Number can be obtained from the insurance Adjuster.
  - The Policy Number is also available on the Motor Vehicle Liability Insurance Card (pink slip).
  - The Claim Number and Policy Number may be the same.
- Enter the date of the accident, using the drop-down calendar or by typing in the year, month and date (YYYY/MM/DD).
  - If the Applicant/Patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

### **Plan Identifier**

- This information will be populated when the Plan is submitted. No action is required.

### **Part 1 – Applicant Information**

- The Applicant/Patient or substitute decision-maker should provide this information to the Facility.
- Enter the date of birth of the Applicant/Patient using the drop-down calendar.

- Select the gender of the Applicant/Patient using the radio buttons.
- Enter the Last Name, then the First Name of the Applicant/Patient.
- Input the Applicant/Patient's address.

The Claim Number or Policy Number and Applicant/Patient First and Last Name must be completed before you can navigate to other tabs on the OCF-23.

**Create OCF23**

STEP 1 2 3 4 NEXT ▶

CANCEL PRINT SAVE

**Claim Identifier**  
Please provide the required claim details. Either the Claim Number or the Policy Number must be provided, as does the Date of Accident.

Claim Number:   
Policy Number:   
\* Date of Accident:  ▼

**Plan Identifier**

OCF Type: 23  
Date: 2016/01/21  
Source: Web  
OCF Effective Date: 2014/07/11  
Archival Status: Not Archived

**Part 1: Applicant Information**  
Please provide all information requested. Values marked with an asterisk (\*) are mandatory fields required for submission. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

\* Date of Birth:  ▼  
\* Gender:  Male  Female  
\* Last Name:   
\* First Name:   
Middle Name:   
\* Address 1:   
Address 2:   
\* City:   
\* Province/State: ON - Ontario ▼  
\* Postal/ZIP Code:   
Phone:

## Part 2 – Auto Insurer Information

- The Applicant/Patient or substitute decision-maker should provide this information to the Facility, including:
  - The Insurance Company Name and Branch Name, both of which can be selected from the drop-down list.
  - The Adjuster name and contact details, if available.



## What about independent adjusting companies and independent Adjusters?


Independent adjusting companies may be hired by Insurers to adjudicate Claims, but the HCAI application does not list independent adjusting companies.


To direct OCFs appropriately, you should ask the Applicant/Patient or the independent Adjuster the name of the licensed Insurer that insures the Applicant/Patient. Some insurance companies may list independent adjusting companies as a "Branch".

### Policy Holder Details

- If the injured person seeking treatment is the Policy Holder, select "Yes" to the question "Is the Policy Holder the same as the Applicant?"
- If the injured person is not the Policy Holder, select "No". Two new fields appear. Enter the last name of the Policy Holder. The name of the Policy Holder can be obtained from the pink slip or the proof of insurance form.

**Part 2: Auto Insurer Information**  
Please provide the applicant's automotive insurer details

\* Company Name:  

\* Branch:  


Adjuster Last Name:

Adjuster First Name:

Phone:

Fax:

**Policy Holder Details**

Is the Policy Holder the same as the Applicant?  No  Yes 

\* Policy Holder Last Name:

Policy Holder First Name:

### Part 3 – Other Insurer Information

- The Applicant/Patient, guardian or substitute decision-maker can advise whether the Applicant/Patient has other insurance. The auto insurance system requires other insurance plans to be accessed before auto insurance health benefits are accessed.



- Health benefits may be available from the Ministry of Health and Long Term Care (MOH) or through the Applicant/Patient’s personal, spousal or parental extended health plan to pay or partially pay expenses listed in the form.
- Space is available for up to two other Insurers in the event that the Applicant/Patient is covered by more than one policy (for example, both the Applicant/Patient and the Applicant/Patient’s partner or legal guardian have extended health benefits).
- If the Applicant/Patient does have other insurance, select the “Yes” radio button.
  - Indicate whether MOH coverage applies<sup>1</sup>.
  - Enter the details of Other Insurer 1 and 2, if applicable.



If there is Other Insurance Coverage, select “Yes” and enter the details in the fields that appear as applicable.

**Part 3: Other Insurer Information**  
 Please provide details for other insurer coverage, where applicable.

\* I have made reasonable enquiries of the applicant and have determined that:

No - There is no other insurance coverage

Yes - There is other insurance coverage that is potentially available to cover / partially cover these goods and services

\* MOH:  **MOH:** Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this plan?

No  Yes  Not Applicable

**Other Insurer 1**

Please provide details for other insurer coverage, where applicable.

Other Insurer Name:

Plan Or Policy Number:

Last Name of Plan Member:

First Name of Plan Member:

Other Insurer's Identifier:

**Other Insurer 2**

Please provide details for other insurer coverage, where applicable.

Other Insurer Name:

Plan Or Policy Number:

Last Name of Plan Member:

First Name of Plan Member:

Other Insurer's Identifier:

<sup>1</sup> Refer to the following link for more information on what goods and services are available through MOH and who is eligible for those goods/services.  
<http://www.health.gov.on.ca/en/public/publications/ohip/motorvehicle.aspx>

# Chapter 2: Tab 2

## Part 4 – Signature of Health Practitioner

The OCF 23 may only be submitted by health care facilities that have a Health Practitioner associated with the facility. External health practitioners are not permitted to sign Part 4 of the OCF-23.

### Name of Provider

- Using the drop-down menus, select the Health Practitioner from your Facility's Provider list and their profession (if they have more than one assigned).

### Is the signature on file?

- The health practitioner must review the Treatment and Assessment Plan with the Applicant/Patient and confirm that the treatment proposed is in accordance with the Minor Injury Guideline.

- In this section, the HCAI web application displays brief attestation wording. Full consent language is viewable on the paper or PDF versions of the OCF-23 only.
- Once the OCF-23 is complete, it must be printed, reviewed, and physically signed by the health practitioner and stored onsite at your facility.
- Select the “Yes” or “No” radio button to indicate that the signature is on file and the OCF-23 has been reviewed by the practitioner.
  - The OCF-23 cannot be submitted unless the answer to this question is “Yes”.
  - Once “Yes” is selected, the Signed Date field will appear. Use the drop-down calendar menu or type in the date of signature (YYYY/MM/DD).

### Is the Provider the initiating Health Practitioner?

- Answer “Yes” or “No” using the radio buttons.

\* Is the signature on file? You must indicate whether you have secured the health care professional/practitioner's signature and retained on file a signed copy of the paper version of this form. You may be required to produce a copy of the signed form at the request of the insurer.

No  Yes

\* Signed Date: 2016/07/15

Is the Provider the first Initiating Health Practitioner?  No  Yes







### The Financial Services Commission of Ontario (FSCO) has implemented business rules for OCF signatures.

Part 4 of an OCF-23 must be signed by a Health Practitioner who is associated with your facility.


For more information on Signatures and the OCF-23, please review HCAIinfo's [OCF-23 eLearning resources](#).

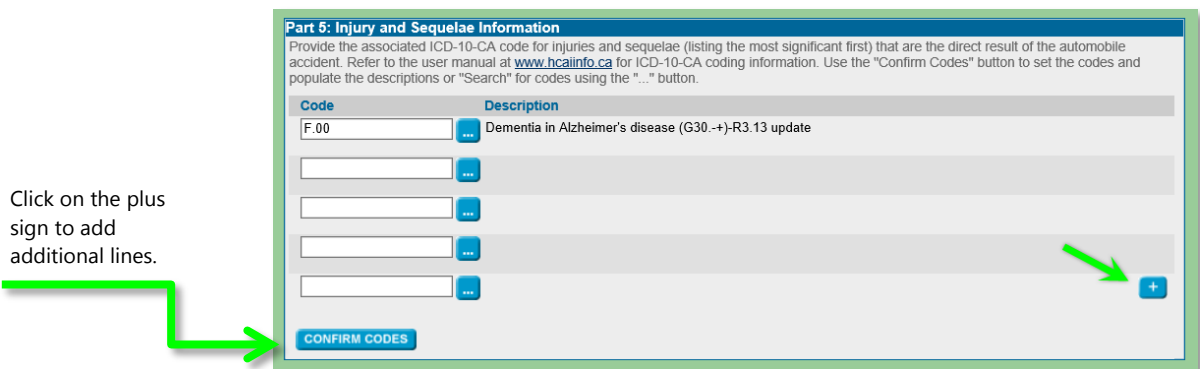
## Part 5 – Injury and Sequelae Information

List the injuries and sequelae that are a direct result of the automobile accident. Standard, non-editable descriptions will be provided with the corresponding injury code (ICD-10-CA).

- If you know the injury/problem code you wish to use, enter it and click on "Confirm Codes" 
- To search for a code from the ICD-10-CA list, click on the  button to open the Injury Code Lookup window.
  - Select the "Series" first, using the drop-down menu.
  - Once a "Series" has been selected, you can pick a "Category" from the drop-down menu and click on the  button.
  - A list of applicable codes appears. Click on the  button to include the code in the plan.
- Each code should be listed only once, regardless of how many Health Care Providers will be engaged in the treatment.
- The first line item should reflect the primary injury/problem you are proposing services, with the most significant injury first.
- In a case where multiple injuries may be classified as the most significant, list the injury requiring the most services first.
- The use of ICD-10-CA codes is intended to classify problems; it is not the equivalent of communicating a diagnosis.

### Adding additional lines for injury/sequelae codes

- To add lines for additional injuries, simply click on the  button near the bottom right of the Injury and Sequelae Codes section.



For more information, refer to the list of Injury and Sequelae codes available on HCAIinfo's [Coding page](#), or contact your Health Professional Association.

## Part 6 – Prior and Concurrent Condition

- This part of the OCF-23 helps the Insurer to better understand the Applicant/Patient’s pre-accident and overall health status.
  - Use this section to inform the Insurer of any pre-existing condition(s) that may affect the Applicant/Patient’s response to treatment.
  - If “Yes” is selected as a response to part B in this section, a new text field appears where you can enter any additional information around prior conditions that may affect recovery.
  - In addition, part C appears, asking if the Applicant/Patient received treatment for any prior conditions in the past year. If “Yes” is selected for part C, a new text field appears to provide details and identify the provider, if known.
- Provide relevant information to the best of your knowledge and based on information from the Applicant/Patient.
  - A response of “Unknown” may prompt a request for further clarification from the Insurer.
- **Please note:** this section seeks information on pre-existing conditions that *may affect the Applicant/Patient’s response to treatment*. If there is a prior condition that has no bearing on the injury or its treatment, you do not have to list that condition.
- If additional space is required, use the space under “Additional Comments” in Tab 4.

If you select “Yes” in part B or C, you must add an explanation to the text field that appears.

**Part 6: Prior and Concurrent Conditions**  
The information provided in this section will help the insurer to better understand the applicant's pre-accident status and informs the insurer in advance of any pre-existing condition that may affect the applicant's response to the treatment given within the PAF or Minor Injury Guideline. Provide relevant information in response to these questions to the best of your knowledge and based on information from the applicant.

\* a ) Was the applicant employed at the time of the accident?  
 No  Yes

\* b ) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 5?  
 No  
 Yes - (Please explain)  
 Unknown

\* c ) If Yes to "b" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year?  
 No  
 Yes - (Please explain and identify provider, if known)  
 Unknown

## Part 7 – Barriers to Recovery

- If there are circumstances that may affect the Applicant/Patient’s recovery, select “Yes.”
  - A new text field appears for you to provide a brief description of the barriers to recover for the Applicant/Patient.

If you select “Yes” you must add an explanation to the text field that appears.

**Part 7: Barriers to Recovery**  
Identify any barriers to recovery that may affect the success of this treatment for this particular applicant. (For assistance in identifying barriers to recovery, please refer to the user manual at [www.hcainfo.ca](http://www.hcainfo.ca))

**A) Have you identified any other barriers to recovery?**

No  Yes - (Please Explain)

**CANCEL** **PRINT** **SAVE**

# Chapter 3: Tab 3

## Part 8 – Direct Payment Assignment

- If your facility holds a valid Service Provider Licence and is to be paid directly by the insurer, select the “Yes” radio button to indicate that the Applicant/Patient has provided consent.
  - Ensure the Applicant/Patient understands this section before they provide their consent.
  - Once the OCF-23 is completed in HCAI, print and have the Applicant/Patient initial the paper form and retain this copy for your facility records.
- If your facility is not licensed, select the “No” radio button.



### **Applicant/Patient consent does not override Service Provider Licensing rules.**

Only facilities with a valid Service Provider Licence at the time of treatment and invoicing are allowed to be directly paid by the insurer.

Receiving Applicant/Patient consent for your facility to be directly paid by the insurer does not override existing SPL rules. For more information on SPL, review HCAIinfo’s [Service Provider Licensing page](#).

## Part 9 – Signature of Applicant

- Complete the treatment plan and review with the Applicant/Patient or substitute decision-maker.

- Select "Yes" or "No" to the question "Is the applicant's or substitute decision-maker's signature on file?"
  - Once the "Yes" radio button is selected, fields appear with the Applicant/Patient or substitute decision marker's first name and last name.
  - Enter the date that they signed the OCF-23.
- Select "Yes" or "No" in response to the question "Is the applicant's or substitute decision-maker's signature waived by the insurer?"

Enter the First and Last Name as well as the signed date.

**Part 8: Signature of Applicant**  
 You must indicate whether you have secured and retained on file a signed copy of the paper version of this form. You may be required to produce a copy of the signed form at the request of the insurer.

\* Is the applicant's or substitute decision maker's signature on file?  No  Yes

\* Applicant's or Substitute Decision Maker's First Name:

\* Applicant's or Substitute Decision Maker's Last Name:

Signed Date:

\* Is the applicant's or substitute decision maker's signature waived by the insurer?  No  Yes

## Part 10 – Guideline Services

### Identify which Guideline is applicable

- The Minor Injury Guideline (MIG) for accidents that occurred on or after September 1, 2010 is already populated in this field.
  - Enter the Estimated Fee.

### Supplementary goods and services

- If applicable, detail any Supplementary Goods and Services required and enter the Estimated Fee.
- For more information on the amounts available for Supplementary Goods and Services, refer to the [Minor Injury Guideline](#).

### Other Pre-Approved Services (including radiology)

- Indicate which Pre-Approved Services are applicable.
- Select the Views for each corresponding code, using the drop-down menu.

### Maximum Fee

- This column displays the maximum fee for Minor Injury Guideline items.

### Estimated Fee



- Enter the Estimated Fee for each code.
- Click on the Calculate button to see the Auto Insurer total.
- If the Estimated Fee of a line item exceeds the Maximum Fee, a symbol will appear beside the item and a message will appear at the top of Part 10 advising that the proposed amount exceeds the maximum allowable limit under the FSCO Minor Injury Guideline.
- You will still be able to submit the OCF-23 if the message displays.
- The Insurer will see the same message.

Enter Supplementary Goods & Services and Other Pre-approved Services along with an Estimated Fee.

**Part 10: Guideline Services**  
 Select the Guideline goods and services to be delivered and enter the expected charged fee. Refer to the user manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for coding information. Attribute codes are described in the manual. Click [here](#) for a link to access the Minor Injury Guideline via HCAIINFO.

Category	Description	Maximum Fee	Estimated Fee	
* Identify which Guideline is applicable	Minor Injury	1,800.00	1000.00	
Supplementary Goods and Services	<input type="text"/>	400.00	<input type="text"/>	
Other Pre-approved Services (including radiology)				
Code	Description	Views	Maximum Fee	Estimated Fee
3SC10	X-Ray of the Cervical Spine	2 or fewer (CXA) ▼	36.80	36.80
3SC10	X-Ray of the Thoracic Spine	Select a view. ▼		<input type="text"/>
3SC10	X-Ray of the Lumbar Spine	Select a view. ▼		<input type="text"/>
3SC10	X-Ray of the Lumbosacral Spine	Select a view. ▼		<input type="text"/>

Auto Insurer Total: 1,036.80

**CALCULATE**

This message is displayed because the Estimated Fee of the Supplementary Goods and Services line exceeds the Maximum Fee.

**Part 10: Guideline Services**  
 Select the Guideline goods and services to be delivered and enter the expected charged fee. Refer to the user manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for coding information. Attribute codes are described in the manual. Click [here](#) for a link to access the Minor Injury Guideline via HCAIINFO.

† Please be advised that the proposed amount on this line item exceeds the maximum allowable limit under the FSCO Minor Injury Guideline.

Category	Description	Maximum Fee	Estimated Fee	
* Identify which Guideline is applicable	Minor Injury	1,800.00	1000.00	
Supplementary Goods and Services	Example <input type="text"/>	400.00	3000.00 †	
Other Pre-approved Services (including radiology)				
Code	Description	Views	Maximum Fee	Estimated Fee
3SC10	X-Ray of the Cervical Spine	2 or fewer (CXA) ▼	36.80	36.80
3SC10	X-Ray of the Thoracic Spine	Select a view. ▼		<input type="text"/>
3SC10	X-Ray of the Lumbar Spine	Select a view. ▼		<input type="text"/>
3SC10	X-Ray of the Lumbosacral Spine	Select a view. ▼		<input type="text"/>

Auto Insurer Total: 4,036.80

**CALCULATE**

# Chapter 4: Tab 4

## Additional Comments & Attachments

**Additional Comments**  
Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer. It is mandatory to indicate the number and types of documents/reports that are being sent.

Attachments being sent, if any.

Family physician report.

- HCAI permits Facilities to do the following:
  - Offer more information to Adjusters by using the space provided in Tab 5.
  - Advise Adjusters that additional documentation (attachments) are being sent which the Insurer requires to adjudicate the form.

### How should attachments be sent?

- Attachments must be faxed/mailed directly to the Adjuster.
  - Attachments cannot be sent electronically via HCAI and should not be sent to HCAI.
- To indicate that an attachment is being sent to the Adjuster, check off "Attachments being sent, if any."
  - If this box is ticked, the Facility must use the space below to describe the attachment being sent.

## Signature(s) on OCF-23 - Printing the completed OCF

- Signatures are not transmitted to the Insurer; however, hard copies of the OCF must be printed, signed by the Provider(s) and the Applicant/Patient or substitute decision maker and kept on file at the Facility.
- Before obtaining signatures, the entire OCF should be completed.
- To print n OCF-23:

- o Click on the **PRINT** button located at the top and bottom of the OCF page.
- o You can also print the OCF after it has been submitted. After pressing the submit button, the successful submission window will appear. Click on the **PRINT** button. When printing after submission, the HCAI document number will automatically be displayed on the printed OCF.
- o Depending on your internet browser settings, the document may immediately download or you may need to select whether to open or save the document.
  - For more information on changing your Internet Browser's pop-up settings, please review the Pop-ups section of HCAIinfo's [Computer Requirements & Tips page](#).

Click the print button after submission to print the completed OCF

Claim Identifier	Return this form to:	Plan Identifier
Applicant Name: hi, Hi Claim Number: 2545432 Policy Number: Date of Accident: 2016/07/15	Nova Insurance 11 Millard St. Peterborough, Ontario M1M1M1	Document Number: 17081700012 OCF Type: 23 Date Submitted: 2017/08/17 Source: Web OCF Effective Date: 2016/07/22 Archival Status: Not Archived

You have submitted document number 17081700012. Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer.

**PRINT** **CLOSE WINDOW**