

IMPORTANT – HOW TO COMPLETE THE HCAI ENROLMENT PROCESS

You must fax or mail back those pages that contain:

1. Facility Details
2. Facility Signature (of Owner/Authorizing Officer)
3. Health Care Provider Table

DO NOT SEND BACK the HCAI Paper Provider Terms and Conditions portion of this document or any Dependent Provider HCAI Terms and Conditions forms. These forms must be retained by the Facility Owner as described in the HCAI Paper Provider Terms and Conditions.

HCAI PAPER SUBMISSION PROVIDER ENROLMENT FORM

Health care facilities and providers who bill insurers on their own behalf in Ontario must register with Health Claims for Auto Insurance Processing (“HCAI”) in order to submit medical and rehabilitation treatment plans, invoices and other documents to HCAI on behalf of automobile insurers in Ontario where required to do so by a Guideline issued by the Superintendent of Financial Services pursuant to the *Statutory Accident Benefits Schedule*, as amended (the “SABS”). Your rights and obligations in respect of the HCAI system and service, and your relationship with HCAI, will be governed by the HCAI Paper Provider Terms and Conditions (the “HCAI Paper Provider Terms and Conditions”) if you submit such documents to HCAI in paper (as opposed to electronic) form.

Your signature on this form will signify your agreement to the HCAI Paper Provider Terms and Conditions. Copies of the HCAI Paper Provider Terms and Conditions are available at www.hcaiinfo.ca. A copy of the HCAI Paper Provider Terms and Conditions, specific to your selected mode of access (paper submission), is attached to this Enrolment Form.

You are responsible for the accuracy and completeness of the information you provide and for the consequences of any error in any information you submit. You agree that you will not attempt to secure unauthorized access (for example, through means such as misrepresenting your identity or misrepresenting your authority to act for or submit information in respect of any other person) to the HCAI system or any HCAI information. HCAI may log and monitor use of the HCAI system to ensure quality and security. Unauthorized activity or access may be subject to prosecution.

<p>Facility Details</p> <p>Facility Name _____ _____</p> <p>Corporation Number (if applicable) _____ Address _____ _____</p> <p>City _____ Province _____ Postal code _____ Telephone _____ Fax _____</p>	<p>Authorizing Officer</p> <p>Name (First and Last) _____</p> <p>Email (if applicable) _____ _____</p>
<p>Payee Information</p> <p>Cheque Payable To _____ _____</p> <p>Lock Payable YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Payee Name (if applicable) _____</p>	<p>Contact One</p> <p>Name (First and Last) _____</p> <p>Title _____ Telephone _____ Email (if applicable) _____</p> <p>Contact Two</p> <p>Name (First and Last) _____</p> <p>Title _____ Telephone _____ Email (if applicable) _____</p>

APPLICABLE TO PROVIDERS AND OWNER/AUTHORIZING OFFICER OF THE FACILITY:

You authorize HCAI to:

1. collect, retain and use the information provided on this form, your other contact information, your treating/prescribing information and any claims submitted by you or on your behalf, only as required by HCAI to discharge its obligations under the SABS,
2. disclose this information to automobile insurers from whom you or your patients seek payment of health benefit claims under the SABS, only as required by such insurers in order that they may investigate and process such claims as required by law, and
3. disclose this information (excluding any personal information that would identify a specific patient) to the Insurance Bureau of Canada (IBC) for the purposes of (i) preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud; and (ii) without using names, professional registration numbers or any other information that would identify a specific health care provider or facility, identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims, including by classes or types of health care providers.

HCAI's privacy statement is available at www.hcaiinfo.ca.

You will not attempt to secure access to any HCAI information except in respect of the claimants to whom you have provided treatment and for whom you have submitted data to HCAI.

FACILITY SIGNATURE:

Owner/Authorizing Officer Information

By signing this HCAI enrolment form, I understand and agree to the provisions set out in this document and the HCAI Paper Provider Terms and Conditions.

Name: _____
(Print your name)

Signature: _____

Date: _____
yyyy/mm/dd

Note: Paper submission providers who deliver services to claimants through and on behalf of this Facility and for whose services payment is made to the Facility do not need to sign this enrolment form for the purposes of their work for this facility. However, such Provider(s) is/are required to sign the Dependent Provider HCAI Terms and Conditions (Appendix A of the HCAI Paper terms and Conditions). It is the responsibility of the facility to retain a signed copy for each such provider of the Dependent Provider Terms and Conditions.

Neither the HCAI Paper Provider Terms and Conditions nor signed copies of the Dependent Provider HCAI Terms and Conditions are to be sent to HCAI Processing Data Entry Centre.

