



Health Claims for Auto Insurance

September 1, 2010 Auto Reforms: OCF-23

OCF-23, Pre-09/01/2010

Form name changes

**Pre-approved Framework
Treatment Confirmation Form
(OCF-23/198)**

~~Use this form for accidents that occur on or after October 1, 2003~~

**Claim Number:	
**Policy Number:	
Date of Accident: <small>(YYYYMMDD)</small>	

To the Applicant:
Please complete Parts 1 and 2. After your health practitioner has reviewed your Treatment Confirmation Form with you, sign Part 13.

Your health practitioner will complete all other parts of the form. A health practitioner (chiropractor, dentist, occupational therapist, optometrist, physician, physiotherapist, nurse practitioner, psychologist, speech language pathologist) must sign Part 5.

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:

To the Initiating Health Practitioner:
Use this form for accidents that occur on or after October 1, 2003 for goods and services provided in accordance with a Pre-approved Framework (PAF) Guideline.

Consent: It is the responsibility of the initiating Health Practitioner to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. The Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* can be used as a consent form.

OCF-23, 09/01/2010

Return this form to:

New name for the OCF-23

Treatment Confirmation Form (OCF-23)

Use this form for accidents that occur on or after October 1, 2003

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

To the Applicant:
Please provide information for the completion of Parts 1, 2 and 3. After your health practitioner has reviewed your Treatment Confirmation Form with you, sign Part 8.

Your health practitioner will complete all other parts of the form.

Collection, use and disclosure of this information are 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 Initiating Health Practitioner:

For accidents that occur before September 1, 2010, this form is to be used for goods and services provided in accordance with the Pre-approved Framework Guideline for Grade I and II Whiplash Associated Disorders (PAF Guideline).

For accidents that occur on or after September 1, 2010, this form is to be used for goods and services provided in accordance with the Minor Injury Guideline.

A Health Practitioner who is authorized by law to treat the impairment, who is authorized under the applicable Guideline to complete this form, and who will be the Health Practitioner responsible for providing the goods and services described in this form must sign Part 4.

Consent: It is the responsibility of Health Practitioners to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. The Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* may be used as a consent form.

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Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Pre-approved Framework Treatment Confirmation Form if,

- i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the person or another person, of goods or services contemplated by the Pre-approved Framework Treatment Confirmation Form. Conflict of Interest definition removed
- ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Part 5 Signature of Initiating Health Practitioner

Name of Initiating Health Practitioner (please print)		College Registration Number	
Facility Name (if applicable)		AISI Facility Number (if applicable)	
Address Part 5 become Part 4 on new OCF-23			
City	Province	Postal Code	
Telephone Number - -	Extension	*Fax Number - -	
*Email Address			

You are a:

- Chiropractor
- Dentist
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physician
- Physiotherapist
- Psychologist
- Speech-Language Pathologist

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Part 5 Signature of Initiating Health Practitioner	Name of Initiating Health Practitioner (please print)		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City	Province	Postal Code		
	Number	Extension	*Fax Number		
	Address				
<input type="checkbox"/> I am not the first Initiating Health Practitioner					
Conflict of Interest Declaration <input type="checkbox"/> I wish to declare that I have no conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form, <i>and</i> 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 <input type="checkbox"/> I am declaring the following conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form:					
I certify that the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6, and the treatment proposed is in accordance with a PAF Guideline. I have reviewed the proposed treatment with the applicant.					
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, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and <u>detecting and preventing fraud.</u>					
Name of Initiating Health Practitioner (please print)		Signature of Initiating Health Practitioner		Date (YYYYMMDD)	

Conflict of Interest section removed

Conflict of Interest Declaration
 I wish to declare that I have no conflicts of interest relating to this Pre-approved Framework Treatment Confirmation 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 Pre-approved Framework Treatment Confirmation Form:

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Part 4 Signature of Initiating Health Practitioner <input type="checkbox"/> I am not the first Initiating Health Practitioner	Name of Initiating Health Practitioner (please print)		College Registration Number	You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist
	Formally Part 5, Signature of Initiating Health Practitioner is now Part 4		AISI Facility Number (if applicable)	
	Address			
	City	Province		
	Telephone Number	Extension		
	*Email Address			
<p>I certify that the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 5 and the treatment proposed is in accordance with the PAF Guideline (if the accident occurred before September 1, 2010) or the Minor Injury Guideline (if the accident occurred on or after September 1, 2010). I have reviewed the proposed treatment with the applicant.</p> <p>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, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.</p>				
Name of Initiating Health Practitioner (please print)		Signature of Initiating Health Practitioner		Date (YYYYMMDD)

Optometrists, Speech Language Pathologists, & Psychologists are now prohibited from signing the OCF-23



Health Claims for Auto Insurance

For more information about the Auto Reforms visit:
www.hcaiinfo.ca