



Health Claims for Auto Insurance

**OCF-23:  
TREATMENT CONFIRMATION FORM**

**Manual for DEC Users**

**Effective September 2010**

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## Document Change History

Date	Description of Change	Reason
20050214	Revised Applicant Signature, Signature of the Initiating Health Practitioner & Prior & Concurrent Conditions, Repositioned Signature of Insurer	For consistency with revised OCF forms 01/Dec/04
20060301	Further Information and Revised Applicant Signature	Redirects Users to HCAI website and revised consent for consistency.
20100621	Form name change, Changes in Part 9, Note about Total in Part 11, Remove Part 4, Renumber the part numbers, Note in Part 4 about signature, Conflict of Interest removed from Part 5.	Changes as of September 1, 2010

## Introduction

### ***Who should use this manual?***

The OCF-23 Treatment Confirmation form is to be used to notify an insurer that the health care facility (HCF) intends to treat an injured patient in the Pre-Approved Framework (if the accident date is prior to September 1, 2010) or in the Minor Injury Guideline (for accident dates on or after September 1, 2010).

This User Manual is designed to assist both health care providers and automobile insurers in the completion of the OCF-23 Treatment Confirmation Form. Other manuals are available to assist in the completion of:

- **OCF-18**            **Treatment Plan**
- **OCF-21**            Auto Insurance Standard Invoice

Health care providers and automobile insurers have dedicated much time and thought to the revision of the Pre-approved Framework and Minor Injury Treatment Confirmation Form and other forms. These forms are intended to enhance communication between insurers and health care professionals.

All forms use the national coding standards, the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada* (ICD-10-CA)<sup>1</sup>, to identify injuries and the *Canadian Classification of Health Interventions* (CCI)<sup>1</sup> to classify health care services and procedures.

### ***What is in this manual?***

The manual provides detailed instructions for completion of the fields in the order in which they appear on the forms. Users of this form should familiarize themselves with the standard code-sets that must be used to classify injury(ies) and treatment interventions. Partial pick-lists of codes are available at the HCAI Information website at [www.hcaiinfo.ca](http://www.hcaiinfo.ca), or from your health professional association.

### ***Where can I get more information?***

The manual will be updated from time to time. The latest updates to the manual can be downloaded from the website [www.hcaiinfo.ca](http://www.hcaiinfo.ca) under Health Care Facility Provider > Dec Access > Working with OCFs.

Contact your professional association for any questions relating to coding of injuries, interventions, health care services and guidelines as they relate to your specific practice.

### ***Samples of Completed Sections of the Forms***

**The samples and fees used throughout the manual are entirely fictitious.** They are designed to assist you in understanding how to use and complete the forms.

## **OCF-23    Treatment Confirmation Form**

### ***Background***

The health practitioner who initiates pre-approved treatment for an injury defined in Pre-approved Framework (PAF) (for accidents before September 1, 2010) and the Minor Injury Guideline (MIG) (for accidents on or after September 1, 2010) must fully complete a Treatment Confirmation Form, OCF-23, in order to establish the Initiating Health Practitioner's right to reimbursement for the delivery of PAF/MIG treatment. The OCF-23 is also the form used to request insurer approval of those treatments that are permitted to be delivered together with treatment in the PAF, but which also require insurer approval.

Purpose:

- To classify the injuries which are a direct result of the motor vehicle accident.

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<sup>1</sup> ICD-10-CA and CCI are copyright products of the *Canadian Institute for Health Information (CIHI)* and may not be changed without the Institute's express permission.

- To identify to the insurer the relevant PAF/MIG program of care and any related pre-approved goods and services that will be provided.
- To request insurer approval of any treatments permitted in the PAF that require pre-approval.
- To provide speedy confirmation to the provider that there is an insurance policy in existence to enable reimbursement.
- To identify any prior conditions and/or barriers to recovery that could affect the claimant's response to the treatment.

This form may not be materially altered; in other words, the document cannot be changed in any manner. If this document is materially altered, it may be considered incomplete and the insurer may not accept the form.

**Note:** *Accidents prior to September 1, 2010 are only eligible for treatment in the PAF guidelines*

### **When should an OCF-23 be submitted?**

The OCF-23 should be submitted as soon as possible after the initial visit with the initiating health practitioner and no later than:

- 5 business days if it is a PAF Confirmation Form, and
- 10 business days if it is a (MIG) Treatment Confirmation Form.

After receipt of the OCF-23, the insurer has five business days to inform the provider that there is an insurance policy in place to respond to invoices. Data Entry Centre (DEC) users will receive this notification by fax.

There will normally be only one OCF-23 per patient. However, exceptions to this can occur, including when:

- an ancillary service\* is proposed by the initiating practitioner, family physician or insurer, either when the PAF is initiated or after treatment is underway. The proposal and approval of the ancillary service are documented through an OCF-23 that is signed by the initiating health practitioner or the patient's physician. Thus, if the insurer wishes to initiate an ancillary service, the insurer shall do so by contacting either the initiating practitioner or the patient's family physician, who will complete the OCF-23;
- the initiating practitioner determines, after treatment is underway, that the patient needs a good (e.g. equipment) to support treatment or that a supplementary condition exists which requires the Supplementary Condition service;
- the patient decides to change practitioners while there are resources remaining in the PAF/MIG, in which case the patient and second practitioner must inform the insurer through submission of a new OCF-23.

*\*Refer to the **PAF/MIG Guidelines** for more information. An ancillary service may be used to identify and evaluate areas of functional difficulty or barriers to recovery and to implement strategies for recovery*

### **Who completes this form?**

The initiating health practitioner who undertakes the responsibility for treating the patient in the PAF/MIG completes and submits the OCF-23. Health practitioners are expected to communicate with their patient, the insurer and other health providers to avoid duplication and promote coordination of services.

By signing Part 4, the health practitioner is affirming that the goods and services contemplated are reasonable and necessary for the injuries described in Part 5.

The applicant or a substitute decision maker completes Part 1 and 2 and signs Part 8. The *Substitute Decisions Act* states that a substitute decision maker is a person with power of attorney for personal care or a court appointed guardian.

The insurer completes Part 12 and returns a copy of the page to the applicant and the health practitioner.

### **Fee**

The fee for completion of this form is embedded in the *Initial Visit* block funding structure of the PAF/MIG. Therefore, the insurer may not be billed separately for completion of this form.

Return this form to: ABC Insurance Company P.O. Box 123, Station 'A' Toronto, ON M1M 1M1 Attn: Mary MacGregor	<h2 style="margin: 0;">Treatment Confirmation Form (OCF-23)</h2> <p style="font-size: small;">Use this form for accidents that occur on or after October 1, 2003</p>						
	<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">**Claim Number:</td> <td>1234567-001</td> </tr> <tr> <td>**Policy Number:</td> <td>9876543</td> </tr> <tr> <td>Date of Accident: <small>(YYYYMMDD)</small></td> <td>20101101</td> </tr> </table>	**Claim Number:	1234567-001	**Policy Number:	9876543	Date of Accident: <small>(YYYYMMDD)</small>	20101101
**Claim Number:	1234567-001						
**Policy Number:	9876543						
Date of Accident: <small>(YYYYMMDD)</small>	20101101						

**Return this form to:**

Enter the name and mailing address of the Insurance Company responsible for handling the claim.

**NOTE:** Independent Adjusting companies are NOT licensed insurers. If you insert the name of an Independent Adjusting Company, your submission will not be processed by the DEC and an error report will be issued.

**Claim Identifiers**

The Applicant **must** indicate:

1. Claim number and/or the policy number. The Claim Number and Policy Number may be the same.
  - a. At least **one** of these fields must be completed.
  - b. The claimant will receive this information from the insurer.
  - c. The health care facility may also wish to confirm the claim/policy number with the insurer.
  - d. If the claimant does not have the information, it is available on the Motor Vehicle Liability Insurance Card (pink slip) received with the policy declaration.

Date of the accident. If a patient has overlapping injuries from more than one accident, use the date of accident that is most relevant to the injuries being treated.

**Part 1 Applicant Information**

<b>Part 1 Applicant Information</b>  <small>To be completed by the applicant</small>	Date of Birth (YYYYMMDD)	Gender	Telephone Number	Extension
	19490525	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	(416) 555-5555	4222
	Last Name			
	Smith			
	First Name		Middle Name	
	Jonathan		James	
Address				
123 Main Street				
City	Province	Postal Code		
Toronto	ON	M9M 9M9		

To be completed by the Applicant.

## Part 2 Insurance Company Information

<b>Part 2 Automobile Insurer Information</b>	Company Name <b>ABC Insurance Company</b>		City/Town or Branch Office (if applicable) <b>North York</b>		
	Adjuster Last Name <b>MacGregor</b>		Adjuster First Name <b>Mary</b>		
	Adjuster Telephone <b>(416) 555-5555</b>		Extension <b>4777</b>	Adjuster Fax <b>(416) 555-5555</b>	
	Name of policy holder: Same as Applicant <input type="checkbox"/> OR		Policy Holder Last Name <b>Smith</b>	Policy Holder First Name <b>Jessica</b>	
To be completed by the applicant					

To be completed by the Applicant.

## Part 3 Other Insurance Information

<b>Part 3 Other Insurance Information</b>	<b>OTHER INSURANCE:</b> Is there other insurance coverage for any goods and services listed in this Treatment Confirmation Form? I have made reasonable enquiries of the applicant and have determined that:			
	<input type="checkbox"/> <b>NO</b> <i>There is no other insurance coverage identified for these goods and services</i>		<input checked="" type="checkbox"/> <b>YES</b> <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 any goods and services included in this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		
	Other Insurer 1	*Other Insurer Name <b>XYZ Life Insurance Company</b>	*Other Insurance Plan Or Policy Number <b>HAS-87632</b>	
		*Name of Plan Member <b>Jonathan Smith</b>	*Other Insurer's Identifier <b>401-234-321</b>	
Other Insurer 2	*Other Insurer Name <b>WEB Life Insurance Company</b>	*Other Insurance Plan Or Policy Number <b>GPR-7676769-01</b>		
	*Name of Plan Member <b>Jessica Smith</b>	*Other Insurer's Identifier <b>555-454-678</b>		
To be completed by the Initiating Health Practitioner with Information from the Applicant				

Other insurance may be available from the Ministry of Health and Long-Term Care (MOH) or through an applicant's personal, spousal, or parental Extended Health Care plan to cover or partially cover some or all of the goods and services listed.

Indicate if the treatment you will be providing is covered by the MOH.

Determine other insurance coverage that the applicant might have. Space is available for two other insurers in the event that the applicant is covered by more than one policy (for example, if both the applicant and the applicant's partner or legal guardian have extended health benefits).

The auto insurer is not liable for any costs which are payable by any other insurer.

## Part 4 Signature of Initiating Health Practitioner

<b>Part 4 Signature of Initiating Health Practitioner</b>  <input type="checkbox"/> I am not the first Initiating Health Practitioner	Name of Initiating Health Practitioner (please print) Brown Barry		College Registration Number 123456		<b>You are a:</b> <input checked="" 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
	Facility Name (if applicable) Family Care Clinic		AISI Facility Number (if applicable) T3434		
	Address 345 Second Avenue East				
	City Toronto	Province ON	Postal Code M2M 3R4		
	Telephone Number (416) 555-5555	Extension 2424	*Fax Number (416) 555-5555		
*Email Address brown@facilitycare.ca					
<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) Barry Brown		Signature of Initiating Health Practitioner		Date (YYYYMMDD) 20101125	

- Only Health Practitioners can certify an OCF-23.
    - Refer to the SABS to determine which health professions are deemed “Health Practitioners”. Only the Initiating Health Practitioner, who may be a family physician, may sign Part 4. The signature is required before the form can be submitted to the insurer.
  - If you are not the first initiating health practitioner, you must check the box provided.
  - If the insurer wishes to initiate an ancillary service for the purpose of a PAF, the insurer shall do so by contacting either the initiating practitioner or the patient's family physician, who will complete the OCF-23.
  - Before signing Part 4, confirm that the requirements for informed consent have been met. The inclusion of a revised statement of understanding identifies for the Initiating Health Practitioner the range of specific uses that will be made of information related to providing services to injured auto insurance claimants.
- **Note:** *Optometrist, Psychologist and Speech-Language Pathologist can not sign OCF-23s for patients with accident dates on or after September 1, 2010.*

## Part 5 Injury and Sequelae Information

<b>Part 5 Injury and Sequelae Information</b>	Provide a description (list most significant first) and associated ICD-10-CA code for injuries and sequelae that are the direct result of the automobile accident (refer to the User manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for ICD-10-CA coding information).	
	Injury Description	Injury Code
	Whiplash Associate Disorder (WAD2)	S.13.41
	Strain and strain of lumbar spine	S.33.5
	Headaches	G44

**Injury Description field(s) may be left blank.** While it is possible to insert a description in the “Injury Description” field, your description will not be transmitted to the insurer. The standard description associated with the ICD-10-Ca code used will populate this field. If you wish to provide more information to the insurer about the patient’s injury or problem, use the narrative section of the form (i.e., Additional Comments section).

List the PAF/MIG injury first. Up to four injuries/sequelae may be entered with a valid ICD-10-CA code.

Refer to **Appendix A** for further information on ICD-10-CA coding.

Refer any questions regarding injury coding to your provider association or access the website at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) (enter the health care facility portal) at the green link on the left called "Coding"

### Part 6 Prior and Concurrent Conditions

<b>Part 6 Prior and Concurrent Conditions</b>	a) Was the applicant employed at the time of the accident? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (please explain) _____
	c) If Yes to "b" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (please explain and identify provider, if known) _____

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/MIG. Provide relevant information in response to these questions to the best of your knowledge and based on information from the applicant. A response of "Unknown" may prompt a request for further clarification from the insurer.

Inclusion of the question on employment status expands on the insurer's understanding of the applicant's pre-accident status.

### Part 7 Barriers to Recovery

<b>Part 7 Barriers to Recovery</b>	a) Have you identified 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 <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> .) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (please explain) _____
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Identify any barriers to recovery that may affect the success of this treatment.

Refer to **Appendix G** for further information on "yellow flags" specific to the PAF.

## Part 8 Signature of Applicant

<b>Part 8 Signature of Applicant</b>	<p>I have reviewed this form. I have been informed about and agree with the proposed treatment. I certify that, to the best of my knowledge, the information I have provided is accurate. Payment for this treatment is pre-approved, and/or subject to the approval of the insurer. For services requiring insurer approval, I understand that, if I undertake those services prior to approval by the insurer, I may be responsible to my provider for any goods or services provided. All services are subject to coverage issues or exclusions.</p> <p>I consent to sharing of personal information between my Initiating Health Practitioner and my insurer. If this OCF-23 is not being completed by the first Initiating Health Practitioner, I consent to the insurer contacting the first Initiating Health Practitioner to determine the amount of the Guideline goods and services that have been consumed.</p> <p><b>TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:</b></p> <p><b>I UNDERSTAND</b> that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.</p> <p><b>I ALSO UNDERSTAND</b> that this information will be collected and used only as reasonably necessary for the purposes of:</p> <ul style="list-style-type: none"> <li>• Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;</li> <li>• Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;</li> </ul>
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(Partial Print Screen)

Patients should never be asked to sign blank forms. After you have reviewed the form with the applicant (or the applicant's Substitute Decision Maker as defined in the *Substitute Decisions Act*), the patient or substitute decision maker must sign here. The insurer may elect to waive the requirement of the applicant signature, but this should be ascertained in advance.

The consent for the use of information has been revised to reflect the current privacy legislation and other legislation with which insurers must comply. Insurers are responsible for ensuring that claimants understand these conditions when initiating a claim through the submission of an OCF-1.

Should the claimant require more information about the consent or their obligations under the policy, please refer him/her to their insurance claims adjuster.

## Part 9 Guideline Services

Part 9 Guideline Services	Category	Description	Maximum Fee	Estimated Fee
	Identify which Guideline is applicable)	Minor Injury/PAF WAD1/11]	1800.00	1160.00
	**Supplementary Goods & Services	Exercise Ball	400.00	40.00
	**Other Pre-approved Services (including radiology)	X-rays of cervical spine	42.00	42.00
	<b>Part 9 Sub-Total</b>		<b>2242.00</b>	<b>1242.00</b>

- Identify the PAF/MIG guideline under which you are treating (either PAF WAD I/II OR Minor Injury) and indicate the maximum fee allowed under this PAF/MIG, as well as your estimated fee for provision of the services.
  - These two numbers may be different if you anticipate that not all blocks of the PAF/MIG will be required in order to treat and discharge this patient.
- Identify any pre-approved Supplemental Goods and Services or other pre-approved services allowed under the PAF/MIG guideline that the patient will require, and insert the associated maximum and estimated costs.

## Part 10 Other Health Providers (Only applicable to accident dates PRIOR to September 1, 2010)

If your patient has an accident date ON OR AFTER SEPTEMBER 1, 2010, skip this section.

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	OT-C	Bloom	Bob	234567		
B						
C						
D						

**Part 10  
Other Health  
Providers**  
(required only if  
Part 11 Services  
are rendered by  
Other Providers)

- This part should be filled in only if there are goods and services requiring prior approval (Part 11).
- Health Providers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference letters are used to cross-reference information on the Treatment Confirmation Form and the Automobile Insurance Standard Invoice.
- Assign a Provider Type code for each of the health professionals rendering services or prescribing goods.

Refer to **Appendix E** for a complete list of Provider Type codes.

- College Registration or AISI number: If you are **not** using HCAI for submission of these forms, you should provide your college registration number if you are a regulated health professional. If you are an unregulated provider, you can obtain an AISI number by registering at <http://www.aisiregistration.on.ca/>
- If you are submitting the form via the HCAI DEC, you do not need to complete these fields.

**NB** Future implementation of the HCAI system may eliminate the need for an AISI number.

- Because hourly rates are generally not applicable to Pre-approved Frameworks or Minor Injury Guideline, enter N/A (not applicable).
- The exception to this is for PAF claimants (accident date prior to September 1, 2010), the Activities of Normal Living Intervention (ANLI), for which the hourly rate of the provider must be entered.

**Part 11 Other Goods or Services within the Guideline Requiring Insurer Approval**

**This Part is applicable if PAF treatment was used in Part 9. The section will remain empty if the guideline used in Part 9 is Minor Injury.**

*Part 11 Other Goods or Services Within the Guideline Requiring Insurer Approval (Applicable for accidents that occur before September 1, 2010.)	Description	†Code	†Attribute	Provider Reference	Estimated		
					Quantity	†Measure	Cost
	Activities of Normal Living	P.W2.AN		A	3.00	HR	210.00
	Travel Time	A.XX.TT		A	0.33	HR	23.10
	Mileage	A.XXKM		A	50.00	KM	13.75
Note: † Refer to the User Manual coding guidelines posted at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> . Attributes codes are used to further qualify the service codes and are described in the manual.					<b>Part 11 Sub-Total:</b>		246.85
Payment by auto insurer is secondary to available collateral benefits.					<b>Total:</b>		1488.85
Briefly explain why the goods and services in Part 11 are being proposed and the treatment goal:							

This section is for services allowable under the PAF Guideline, but still requiring insurer approval.

## Description

If you are using the HCAI DEC, leave the description section blank. It will be automatically populated with the ICD-10-Ca description associated with the code. If you fill in the description field, it will not be visible to the insurer. If you wish to offer the insurer more information about your treatment, use the “Additional Comments” section of the form.

## Code and Attributes

For those services representing a diagnostic, therapeutic, or health care support intervention, enter a valid CCI code and attribute if required.

Refer to **Appendix B** for a partial pick-list list of CCI codes and corresponding Attribute Codes.

For Goods, Administration and other codes (GAP) not included in the CCI code set, enter a valid GAP code.

Refer to **Appendix C** for a list of valid GAP codes

Refer any questions regarding goods and service coding to your health professional association or refer to the website at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) and navigate to the [coding section](#).

## Provider Reference

Enter the Provider Reference code of the professional who will render the service or is prescribing the good (from Part 10).

Only one provider can be referenced per line item. Do not enter more than one provider in any single line. If more than one provider will deliver services, enter the provider that will be most responsible. .

## Estimated

In the three columns under this heading, you are to enter the elements of information that are needed to calculate the estimated total cost of each good and service that will be delivered.

- First, enter the total quantity of the good or service that will be delivered; this will appear as a number (e.g., 75, 6, 52...).
- Second, identify the unit of measure (e.g., *hours* of service, number of *pages*, and *kilometres* of travel) for the quantity of service you are proposing to deliver each treatment day.
- Third, report the cost per service.

## Sub-Total

Enter the total cost of goods or services proposed in Part 11.

## Total

Enter the combined total of the estimated fees from Part 9 and Part 11.

## Attachments

\*Please indicate any additional comments regarding proposed goods and services:

Are there any attachments?  Yes  No  
If Yes, how many? 3  
Send any attachments directly to the insurer

- If you have supporting documents for this Treatment Plan, check off **Yes** and indicate how many pages will be faxed or mail to the Insurer.
- If no attachments will be sent, check off **No**.

**Note:** If attachments are to be sent, these should be faxed or mailed directly to the insurer, not to the HCAI DEC.

**Part 12 Signature of Insurer**

<b>Part 12 Signature of Insurer</b>	<input type="checkbox"/> I will waive the requirement of the Applicant's signature.		
	<input type="checkbox"/> I have reviewed this Treatment Confirmation Form, and based upon the information provided, I confirm that the policy referred to in Part 2 was in force at the time of the accident.		
	If other goods or services requiring insurer approval have been proposed in Part 11, I:		
	<input checked="" type="checkbox"/> Approve	<input type="checkbox"/> Partially approve (explanation to follow or attached)	<input type="checkbox"/> Do not approve (explanation to follow or attached)
	Name of Adjuster (please print) Mary MacGregor	Signature of Adjuster	Date (YYYYMMDD) 20101125
<b>To the insurer:</b> Please provide a copy of this page to the Applicant and the Initiating Health Practitioner indicated in Part 4.			

The insurer will complete this section and return page 3 to the applicant and the Initiating Health Practitioner indicated in Part 4. If there is a service requiring insurer approval on the plan, and the insurer partially approves or does not approve the treatment, it must provide an explanation as to why the additional service has been declined. In this case, the provider may submit a Treatment Plan (OCF-18) for the declined services, and approval will be subject to the SABS