					A	uto Ir	nsuran	ce St	andard (C	Invoice OCF-21)	
						Claim	n Number:		,	,	
						Policy	y Number:				
							Accident:				
The User Manual fo Attach Version C - assessment plan. ' assessments, at the Please provide all in	r completion of the pages 2 and 3 for Version B - pages discretion of the Information request	•	may be four neworks (PA d for all oth	nd at www.a AFs). Attao ner goods a	autoins ch Vers and ser	ilitation good urancereforr sion A - pag vices and m	ds and services ms.on.ca. ge 2 where th nay be used fo	ere is a p	reviously approve	ed treatment or	
Part 1	Date Of Birth (YYYY		Gender					hone Number	r	Extension	
Applicant	Last Name	· 		□ м:	ale 📮	Female					
Information											
	First Name					Middle Name	•				
	Address										
	City		Provinc	е			Posta	I Code			
	Company Name				City or	Town of Propo	th Office (if applica				
Part 2 Insurance					Í		л Опісе (ії аррііса	ible)			
Company	Adjuster Last Name	•			Adjust	er First Name					
Information	Adjuster Telephone			Extension	Adjust	er Fax					
	Name of policy hold Applicant OR	der same as: Policy Hold	er Last Name			Policy Hold	er First Name				
Part 3 Invoice	Invoice Number		viously ap	proved	l goods and	• •	•	ete the following:			
Information	First Invoice	Yes No	Type of I	Plan or Pre-a	pproved	Framework	Plan Date (YYYYMMDD)	Plan Number	Approved Amount	Previously Billed	
	Last Invoice	Yes No	_	tment Plan (O		•					
		e (if applicable)		Plan (OCF-1		•					
	Med / Rehab  Disability		Asse	essment Plan	`	•					
	Disability  Post 104 weeks	6	◆ Attac	ch Version A c		*					
	Attendant Care	_		ch Version C							
	☐ Catastrophic	,	For all ot	ner invoices, a	ittach ve	rsion B					
Part 4	Facility Name (if app	plicable)				AISI Facility Nu	umber (if applicabl	e)			
Payee	,	,,				,	`	,			
Information	Payee Last Name					Payee First Na	ime		Payee Number (if app	olicable)	
	Address										
	City			Province		Postal Code					
	Telephone Number			Extensi	ion	Fax Number	-				
	,										
	Email Address										
	<ul> <li>I wish to declare that I have no conflicts of interest relating to this invoice, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this invoice on the part of any person who referred the applicant to a person who provided goods or services referred to in the invoice.</li> <li>Or</li> <li>I am declaring the following conflicts of interest relating to this invoice:</li> </ul>										
	false or mislead the federal <i>Crim</i> This information services that are	e information provided is ling statement or repres ninal Code for anyone, to n will be used for proc e provided to automobil	sentation to by deceit, fa essing payr e accident v	an insurer of Isehood, or ments of clarictims, by h	under a other o aims; i nealth o	i contract of dishonest ac dentifying ar are provider	insurance. I for the to defraud or and analysing the rs; and detecting	urther under rattempt to he nature, ng and pre	erstand that it is a o defraud an insu effects and cost venting fraud.	n offence under rance company. s of goods and	
	Name of Health Pro	ofessional or Authorized Signa	atory (please p	rınt)	Signat	ure of Health P	rofessional or Aut	norized Signa	tory Date (	YYYYMMDD)	

### OCF-21 - Version A - page 2

This form may be used for billing goods and services that have been previously approved by the insurer through an OCF-18, OCF-11, or OCF-22.

This form may not be used for Pre-approved Frameworks (use Version C - pages 2 and 3) or goods and services that have not been previously approved (use Version B - pages 2 and 3).

Ref

A B C Type

Injuries and Sequelae								
Description	Code							
Injury details are not required if they are the same as those on an Refer to the User Manual at www.autoinsurancereforms.on.ca for								

Е			
F			
Provider	details are	not required if they are the same as thos	e on an approved plan.

Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.

**Last Name** 

**Providers** 

G/S	Mon	nth (yyy	/y-mm)																													P S	G S	Cost/	Total	Total
Ref	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	T	T	Day	Count	Cost
Refer to the previously approved plan for each good and service reference number (G/S Ref).  Enter the Provider Reference from the previously approved plan or the Provider table above at the intersection of the date of service and the G/S Ref indicating the provider who rendered or prescribed the service or good.																																				

Sub-Total: MOH Insurer 1 Insurer 2 **Account Activity Since Last Invoice (if** Interest is being charged) MOH: Chiropractic: Other Insurance Physiotherapy: Prior Balance: Other Insurer 1 + 2: GST (if applicable): Massage Therapy: Payment Received PST (if applicable): <sup>1</sup>Other Service Type: from Auto Insurer: <sup>2</sup>Overdue Amount: <sup>2</sup>Interest: Total: <sup>2</sup>The insurer shall pay interest on overdue outstanding <sup>1</sup>Please Specify Other **Auto Insurer Total:** balances as required by the Statutory Accident Benefits Service Type: Schedule.

Make cheque payable to:	
Other Information:	

For insurer's use only										
Reviewed By:										
Approved By:										
Payee Name:										
Payment Amount:	Total	Interest	Grand Total							

Regulated

(College Registration

Number)

First Name

Unregulated

(AISI Number if

applicable, or blank)

**Hourly Rate** 

For Insurer's

Additional sheets attached

## OCF-21 - Version B - page 2

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18, OCF-11, or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

Injuries and Sequelae									
Description	Code								

Injury details are not required if they are the same as those on a previously approved plan.

Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.

		Providers		Regulated (College Registration	Unregulated	Hourly Rate	For Insurer's
Ref	Туре	Last Name	First Name	Number)	(AISI Number if applicable, or blank)		Use
Α							
В							
O							
D							
Е							
F							

Provider details are not required if they are the same as those on a previously approved plan. Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.

Dat	e of Servi	ce	Description		A44 11 4	Provider	Quantity	Measure	GST	PST	Cost
YYYY	MM	DD	·	Code	Attribute	Reference	Quantity	weasure	(✔)	(✔)	Cost
									1		
									+		
									+		
									1		
efer to th	e User Manu	al at www.ai	utoinsurancereforms.on.ca for coding.					Sub-Total			

☐ Additional sheets attached

## OCF-21 - Version B - page 3

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18, OCF-11, or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

OTHER IN	SURANCE: I have made re	asonable enquiri	es of the claiman	t and have determi	ned that:	Conflict	of Interest Definition	
	☐ Yes ☐ No	services	cover/pare (MOH) covers	partially cover these age for goods and	coverage that is potentially available to e goods and services. services included in this invoice?	A person	n has a conflict of interest relating to a  The person or a related person ma benefit, directly or indirectly, as a re the related person, of the goods or	ly receive a financial esult of the provision, by
Other Insurer 1	Other Insurer Name  Name of Plan Member			Other Insurance Pla  Other Insurer's Iden	·	ii.	The person who may receive the fi employee of the person who will pr services and does not have a conti will provide the goods or services of	ovide the goods or ract with the person who
Other Insurer	Other Insurer Name  Name of Plan Member			Other Insurance Pla Other Insurer's Iden	·		services of that kind are provided.	
_	nce details are not required if they are	the same as those o	on a pre-approved pla	ın.				
es		MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice		Sub-Total:	
rvic (e	Chiropractic:				(if Interest is being charged)		MOH:	
<b>surance</b> nd services nvoice)	Physiotherapy:				Prior Balance:		Other Insurer 1 + 2:	
ng no	Massage Therapy:				Payment Received		GST (if applicable):	

e) (e	Chiropractic:		(if Interest is being charged)	мон:	
<b>rar</b> se oic	Physiotherapy:		Prior Balance:	Other Insurer 1 + 2:	
su and inv	Massage Therapy:		Payment Received	GST (if applicable):	
r. Is a	<sup>1</sup> Other Service Type:		from Auto Insurer:	PST (if applicable):	
Other Insurance goods and service on this invoice)	Total:		<sup>2</sup> Overdue Amount:	<sup>2</sup> Interest:	
(for g	<sup>1</sup> Please Specify Other Service Type:		<sup>2</sup> The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.	Auto Insurer Total:	

Make cheque payable to:		For insure
Other Information:	Reviewed By:	
	Approved By:	
	Payee Name:	
	Payment Amount:	Total

For insurer's use only								
Reviewed By:								
Approved By:								
Payee Name:								
Payment Amount:	Total	Interest	Grand Total					

## OCF-21 - Version C - page 2

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework. For all other goods and services attach Version A or B.

Injuries and Sequelae						
Description Code						
Injury details are not required if they are the same as those of	n the Pre-approved					

Providers		Regulated (College Registration	Unregulated (AISI Number if	Hourly Rate	For Insurer's Use			
Ref	Туре	Last Name	First Name	Number)	applicable, or blank)	,	roi ilisulei s ose	
Α								
В								
С								
D								
Е								
F								
Refer to	Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.							

Framework Treatment Confirmation Form (OCF-23/198)
Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.

Goods and Services Rendered (PAF providers are required to declare the information requested below on every treatment, service and good delivered. Failure to provide this information may delay payment)									
	e of Service		Description			Provider			
YYYY	MM	DD	Bescription	Code	Attribute	Reference	Quantity	Measure	
	1								

Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.

Additional sheets attached

# OCF-21 - Version C - page 3

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework. For all other goods and services attach Version A or B.

Reimbursable Fees Within the PAF Guidelines:							
Description	Code	Attribute	Cost				
Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.	F	PAF Fee Totals:					

Other Reimbursable Goods and Services Approved by the Insurer:											
	te of Servi		Description	Code	Attribute	Provider	Quantity	Measure	GST	PST (✔)	Cost
YYYY	MM	DD		Code	Attribute	Reference	quantity	Quantity   Measure (✓)			0001
Refer to the User Manual at www.autoinsurancereforms.on.ca for coding.							Other Goods	and Service	es Total:		

		MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice	Sub-Total:	
e o e	Chiropractic:				(if Interest is being charged)	MOH:	
ner Insurance goods and rices on this invoice)	Physiotherapy:				Prior Balance:	Other Insurer 1 + 2:	
sur ds or ice	Massage Therapy:				Payment Received	GST (if applicable):	
good Sees OV	<sup>1</sup> Other Service Type:				from Auto Insurer:	PST (if applicable):	
Othe (for g Servi	Total:				<sup>2</sup> Overdue Amount:	<sup>2</sup> Interest:	
O E S	<sup>1</sup> Please Specify Other Service Type:				<sup>2</sup> The insurer shall pay interest on overdue outstandir balances as required by the Statutory Accident Benefi Schedule.	Auto Insurer Total:	

Make cheque payable to:	
Other Information:	

For insurer's use only								
Reviewed By:								
Approved By:								
Payee Name:								
Payment Amount:	Total	Interest	Grand Total					