Return this form to:

Treatment Confirmation Form (OCF-23)

Use this form for accidents that occur on or after September 1, 2010.

****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 9.

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 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.

Part 1 Applicant Information

To be provided by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	*Telephone Number Extension
Last Name		
First Name	***Middle Name	
Address		
City	Province	Postal Code

Part 2 Insurance Company Information

To be provided by the applicant

Company Name		City or Town of Branch Office (if applicable)
*Adjuster Last Name		*Adjuster First Name
*Adjuster Telephone Extension		*Adjuster Fax
**Name of Policy Holder: Same as Applicant ☐ OR:	**Policy Holder Last Name	*Policy Holder First Name

Part 3 Other Insurance Information

To be completed by the Initiating Health Practitioner with Information from the Applicant

OTHER INSURANCE: 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:

☐ **NO** *There is no other insurance coverage identified for these goods and services*

☐ **YES** *There is other insurance coverage that is potentially available to cover/partially cover these goods and services.*

MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this plan? ☐ Yes ☐ No ☐ Not applicable	
Other Insurer 1	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier
Other Insurer 2	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier

PRINT RESET SAVE

Part 4 Signature of Initiating Health Practitioner

☐ I am not the first Initiating Health Practitioner

Name of Initiating Health Practitioner (please print)		College Registration Number
Facility Name (if applicable)		
HCAI Facility Registry Number	FSCO Licence Number (if applicable)	
Service Address		
City	Province	Postal Code
Telephone Number Extension		*Fax Number
*Email Address		

You are a:

- ☐ Chiropractor
- ☐ Dentist
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Physician
- ☐ Physiotherapist

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect business, personal and personal health information that is related to the applicant's claim for accident benefits arising out of the accident referenced in this Treatment Confirmation Form and that all such information will be collected directly from me or from any other person with my consent.

I ALSO UNDERSTAND that you and persons acting for you will collect information about this Treatment Confirmation Form prepared by me.

I ALSO UNDERSTAND that as the initiating health practitioner for the applicant that you, and persons acting for you, will collect information related to this claim that is provided by me on this or any other auto insurance claim form.

I ALSO UNDERSTAND that the information within this form will be collected and used only as reasonably necessary, with the applicant's consent, for the purposes of:

- Investigating the claims of the applicant and processing the claims of the applicant as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to the applicant's claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with the applicant's claims;
- Identifying and analysing the nature and costs of goods and services that are provided to automobile insurance claimants by health care providers;
- Preventing, detecting and suppressing fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons or organizations, who may collect and use this information only as reasonably necessary to enable you or them to carry out the purposes described above:

Insurers; insurance adjusters, agents and brokers; employers; health care providers; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations; other insurance companies; the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.

I ALSO UNDERSTAND that you, and persons acting for you, may pool this information with information from other sources and may analyse this information for the limited purpose of preventing, detecting or suppressing fraud.

I CONSENT to you collecting, using and disclosing information relating to this Treatment Confirmation Form in the manner described above, which will be limited to information that is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with the insurance company representative or a legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

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 Minor Injury Guideline (if the accident occurred on or after September 1, 2010). 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. Regulated sectors may be subject to an examination or inquiry about matters in connection with a licence and or unfair or deceptive acts or practices. Non-compliance with applicable regulations may result in enforcement actions ranging from an administrative monetary penalty to prosecution under the Provincial Offences Act.

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 **PREVENTING, DETECTING AND SUPPRESSING FRAUD.**

To obtain further information about privacy related issues please contact the Privacy Officer for the insurance company listed in Part 2.

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit http://www.ibc.ca/en/privacy-terminology.asp

Name of Initiating Health Practitioner (please print)	Signature of Initiating Health Practitioner	Date (YYYYMMDD)

PRINT RESET SAVE

To the Health Practitioner:
Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 5 Injury and Sequelae Information

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 www.hcaiinfo.ca for ICD-10-CA coding information).

Injury Description	Injury Code

Part 6 Prior and Concurrent Conditions

a) Was the applicant employed at the time of the accident?
☐ Yes ☐ 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?
☐ No ☐ Unknown ☐ 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?
☐ No ☐ Unknown ☐ Yes (please explain and identify provider, if known)

Part 7 Barriers to Recovery

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 www.hcaiinfo.ca.)
☐ No ☐ Yes (please explain)

Part 8 Direct Payment Assignment by Applicant

(only applicable to applicants obtaining treatment/service from a licensed service provider)

☐ I direct the insurer, including the Motor Vehicle Accident Claims Fund, to pay the licensed service provider directly for that portion of the approved goods and services specified on this Treatment Confirmation Form (OCF-23) that are not covered by extended/supplementary health insurance.

Applicants that have extended/supplementary health insurance responding to a claim may need to provide payment out of pocket before the extended/supplementary health insurer reimburses the claimant.

Applicant Initials

PRINT RESET SAVE

Part 9 Signature of Applicant

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.

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.

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect 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.

I ALSO UNDERSTAND that you and persons acting for you will collect information about my driving record, automobile insurance policy history and automobile insurance claims history if they exist.

I ALSO UNDERSTAND that if I am the holder of an automobile insurance policy, you, and persons acting for you, will collect the driving record, automobile insurance policy history and automobile insurance claims history of any listed drivers on my automobile insurance policy or other drivers whom I have permitted to drive my automobile.

I ALSO UNDERSTAND that the information described above will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing, detecting and suppressing fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons or organizations, who may collect and use this information only as reasonably necessary to enable you or them to carry out the purposes described above:

Insurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations; other insurance companies; the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.

I ALSO UNDERSTAND that you, and persons acting for you, may pool this information with information from other sources and may analyze this information for the limited purpose of preventing, detecting or suppressing fraud.

I CONSENT and, **if I am the holder of an automobile insurance policy**, declare that I have obtained consent from the listed drivers on my policy and any other drivers whom I have permitted to drive my automobile, to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with my insurance company representative or legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

I CERTIFY that the information provided is true and correct.

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.

To obtain further information about privacy related issues please contact the Privacy Officer for the insurance company listed in Part 2.

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit http://www.ibc.ca/en/privacy-terminology.asp.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

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Applicant Name:		OCF-23	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 10 Guideline Services

Category	Description	Maximum Fee	Estimated Fee
Minor Injury Guideline			
**Supplementary Goods & Services			
**Other Pre-approved Services (including radiology)			
	Total		

Are there any attachments? ☐ **Yes** ☐ **No** **If yes, how many?** _____
Send any attachments directly to the insurer

Part 11 Signature of Insurer

☐ ***I waive the requirement of the Applicant's signature.

☐ 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.

☐ Approve	☐ Do not approve (explanation to follow or attached)	
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

To the insurer: Please provide a copy of this page to the Applicant and the Initiating Health Practitioner indicated in Part 4.

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