OCF 18 - TREATMENT PLAN

USER MANUAL

MARCH 2006

Document Change History

Date	Description of Change	Reason
20050214	Revised Signature of Health Practitioner & Applicant Signature, Repositioned Signature of Insurer	For consistency with revised OCF forms 01/Dec/04
20060301	Revised Further Information, Who completes form, Other Insurance Information, Signature of Health Practitioner & Regulated Health Professional and Health Providers	Redirects users to HCAI website for further information and reflects inclusion of Social Worker as per revised SABS

Changes are underlined.

Introduction

Who should use this manual?

This User Manual is designed to assist both health care providers and automobile insurers in the completion of the OCF–18 Treatment Plan. Other manuals are available to assist in the completion of:

OCF–3	Disability Certificate
OCF–21	Auto Insurance Standard Invoice
OCF–22	Application for Approval of an Assessment or Examination
OCF–23	Pre-Approved Framework Treatment Confirmation Form
OCF–24	Pre-Approved Framework Discharge & Status Report

Facilities and health care providers dealing with victims of motor vehicle accidents are required to use these forms.

Both rehabilitation health care providers and automobile insurers have dedicated a tremendous amount of time and thought to the revision of the Treatment Plan and other forms. These forms will improve the accountability of all parties, streamline the process of delivering health care services to applicants, and enhance communication between insurers and health care professionals.

The forms are designed to facilitate a clear understanding of the interactions amongst an injured motorist, a health care professional and an insurer through the use of common terms and language. All forms use the national coding standards, the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada* (ICD-10-CA)[1], to identify injuries and the *Canadian Classification of Health Interventions* (CCI)[1] 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. The appendices include tables of standardized codes and descriptions for the various codified fields used on the forms.

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 under Auto Insurance Resources>Statutory Accident Benefits>Claims Forms.

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.

[1] 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

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.

Background

Except in the case of treatment provided under a Pre-approved Framework, health professionals must fully complete the Treatment Plan, OCF-18, in order to have a plan of treatment approved and funded. The insurer may waive this requirement.

Purpose:

- To describe the cause and nature of injuries that are a direct result of the motor vehicle accident.
- To identify activities limited by the injury and sequelae.
- To identify the treatment plan goals, how progress on the goals will be measured, and any barriers to recovery.
- To identify any prior and concurrent conditions that could affect the claimant's response to the treatment.
- To describe the treatment proposed and estimated cost.
- To increase accountability of the claimant, health care provider(s) and insurer.

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.

When is an OCF-18 required?

Unless waived by the insurer or in the case of a Pre-approved Framework, a Treatment Plan must be completed before the reimbursement of medical and rehabilitation benefits.

Insurers may choose to agree to pay medical and rehabilitation benefits without requesting a treatment plan. Insurers must provide written confirmation of what they will pay for without a treatment plan. They may later request a treatment plan for future treatment.

Who completes this form?

The applicant or a substitute decision maker completes Part 1 and 2 and signs Part 14. 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.

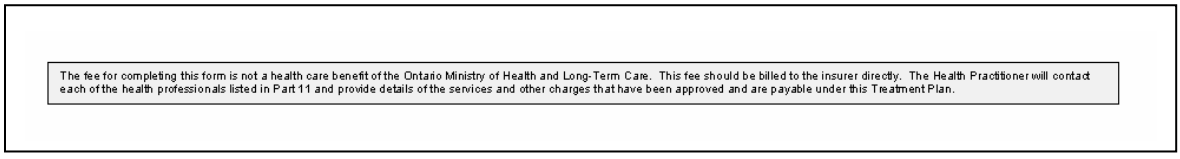
Any regulated health professional or social worker may fill out Part 3 and Parts 6 to 12.

A health practitioner (i.e., chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist or speech-language pathologist) must sign Part 5. In doing so, the health practitioner is stating that the treatment set out in the plan is reasonable and necessary for the injuries set out in Part 7.

The insurer completes Part 13 and returns a copy of the page to the health practitioner indicated in Part 5 and the applicant from Part 1.

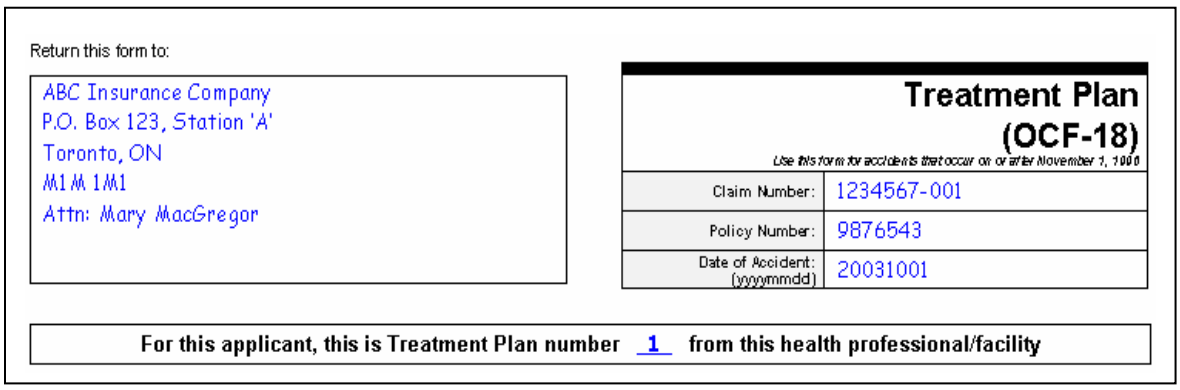
It is important to ensure, where possible, that if more than one health care professional at the same facility is participating in the Treatment Plan, only one treatment plan is submitted per facility for the period of the Treatment Plan. This will allow for a single comprehensive plan, allowing for continuity of care among all health care providers.

Fee



The fee for completion of this form should be billed directly to the insurer. It is not a benefit of the Ministry of Health and Long-Term Care.

It is a conflict of interest to receive any payment or benefit in addition to the insurer's fee for completion of the form.



Return this form to:

ABC Insurance Company
P.O. Box 123, Station 'A'
Toronto, ON
M1M 1M1
Attn: Mary MacGregor

Treatment Plan (OCF-18)

Use this form for accidents that occur on or after November 1, 1996

Claim Number:	1234567-001
Policy Number:	9876543
Date of Accident: (yyyymmdd)	20031001

For this applicant, this is Treatment Plan number 1 from this health professional/facility

Return this form to:

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

Claim Identifiers

The applicant must indicate the claim number if known, the policy number, and the date of the accident. The claim number and policy number can be obtained from the insurance adjuster. The policy number is also available on the Motor Vehicle Liability Insurance Card (pink slip) received with the policy declaration.

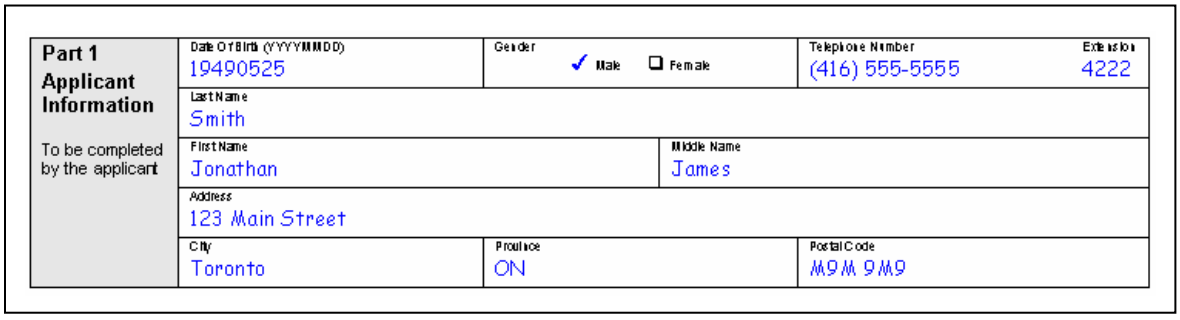
The Claim Number and Policy Number may be the same.

The accident date must be completed. Forms will not be processed without it. If a patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

Treatment Plan Number

Enter a number indicating how many times you have completed a Treatment Plan for this applicant and this motor vehicle accident.

Part 1 Applicant Information



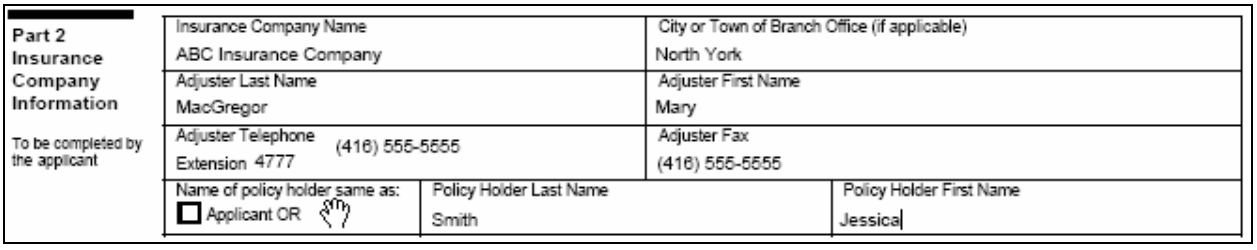
Part 1 Applicant Information

To be completed by the applicant

Date Of Birth (YYYYMMDD): 19490525	Gender: ✓ Male ☐ Female	Telephone Number: (416) 555-5555	Extension: 4222
Last Name: Smith			
First Name: Jonathan	Middle Name: James		
Address: 123 Main Street			
City: Toronto	Province: ON	Postal Code: M9M 9M9	

To be completed by the Applicant.

Part 2 Insurance Company Information



Part 2 Insurance Company Information

To be completed by the applicant

Insurance Company Name: ABC Insurance Company		City or Town of Branch Office (if applicable): North York
Adjuster Last Name: MacGregor		Adjuster First Name: Mary
Adjuster Telephone: (416) 555-5555 Extension 4777		Adjuster Fax: (416) 555-5555
Name of policy holder same as: ☐ Applicant OR	Policy Holder Last Name: Smith	Policy Holder First Name: Jessica

To be completed by the Applicant.

Part 3 Other Insurance Information

Part 3 Other Insurance Information

To be completed by the health professional or social worker responsible for plan preparation and supervision with information from the applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment Plan?
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 Treatment Plan? ☐ Yes ☑ No ☐ Not applicable	
Other Insurer 1	Other Insurer Name XYZ LIfe Insurance Company	Other Insurance Plan Or Policy Number HSA-87651
	Name of Plan Member Jonathan Smith	Other Insurer's Identifier 401-123-321
Other Insurer 2	Other Insurer Name WER Life Insurance Company	Other Insurance Plan Or Policy Number GRP-987622-01
	Name of Plan Member Jessica Smith	Other Insurer's Identifier 444-876-678

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. This section is to be completed by the health professional or social worker responsible for plan preparation and supervision, with information from the applicant.

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 (e.g., 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 that are payable by any other insurer.

Part 4 Conflict of Interest Definition

Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Treatment Plan if,

i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and

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.

Note: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

Before proceeding to the rest of the form, determine if you have a conflict of interest relating to this treatment plan.

Part 5 Signature of Health Practitioner

Part 5 Signature of Health Practitioner Plan Certification

Name of Health Practitioner: Barry Brown		College Registration Number: 123456	You are a: ☑ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable): Family Care Clinic		AISI Facility Number (if applicable): T2222	
Address: 234 Second Avenue East			
City: Toronto	Province: ON	Postal Code: M2M 2M2	
Telephone Number: (416) 555-5555	Extension: 2424	Fax Number: (416) 555-5555	
Email Address: bbrown@famcare.ca			

☑ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, *and* I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.

or

☐ I am declaring the following conflicts of interest relating to this Treatment Plan:

I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional or social worker in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7.

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.

Name of Health Practitioner (please print)	Signature of Health Practitioner	Date (YYYYMMDD)
Barry Brown		

According to the Statutory Accident Benefits Schedule, health practitioners are chiropractors, dentists, nurse practitioners, occupational therapists, optometrists, physicians, physiotherapists, psychologists and speech-language pathologists. Only these professionals may sign Part 5, and the signature is required before the Treatment Plan can be submitted to the insurer. The inclusion of a revised statement of understanding identifies for the Health Practitioner the range of specific uses that will be made of information related to providing services to injured auto insurance claimants.

Before signing Part 5, confirm that the applicant and the regulated health professional or social worker in Part 6 have reviewed the Treatment Plan together to make certain that the requirements for informed consent have been met.

Part 6 Signature of Regulated Health Professional

Part 6 Signature of Regulated Health Professional or Social Worker

Plan Preparation and Supervision if same person as Part 5 check here ☑ and ***DO NOT COMPLETE Part 6***

Name of Regulated Health Professional or Social Worker		Registration Number
Facility Name (if applicable)		AISI Number (if applicable)
Address		
City	Province ON	Postal Code
Telephone Number	Extension	Fax Number
Email Address		

You are a:

- ☐ Chiropractor
- ☐ Dentist
- ☐ Massage Therapist
- ☐ Nurse
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Physician
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Social Worker
- ☐ Speech-Language Pathologist
- ☐ Other_____

☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, *and* I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.

or

☐ I am declaring the following conflicts of interest relating to this Treatment Plan:

I confirm 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.

Name of Regulated Health Professional/Social Worker (please print)	Signature of Regulated Health Professional/Social Worker	Date (YYYYMMDD)

If you completed Part 5, and are also the regulated health professional responsible for the preparation and supervision of the treatment plan, you do not need to complete Part 6. Simply check the box as indicated and continue to Part 7. This section has been revised to reflect the inclusion of social worker.

Unregulated providers may not sign this section.

*Refer to **Appendix E** for a complete list of regulated health professions.*

Part 7 Injury and Sequelae Information

To the Health Professional or Social Worker:
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 7 Injury and Sequela 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.

Description	Code
Sprain adn strain of lumbar spine	S33 5
Headaches	G44

Note *: Refer to the User manual at www.hcalinfo.ca for ICD-10-CA coding information.

List the injuries and sequelae that are a direct result of the automobile accident. Provide a brief description of the injury and the corresponding injury code (ICD-10-CA code). Up to six injuries/sequelae may be entered including the description and a valid ICD-10-CA code.

List the most significant injury first; describe the patient's most significant condition that is directly related to the automobile accident and that requires health care services. In a case where multiple injuries may be classified as the most significant, list the injury requiring the most services.

It is anticipated that, with the use of "multiple injury" codes (see Appendix A) there will likely not be more than six injury/sequelae codes needed. However, should more space be required, you may attach an additional page.

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

Refer any questions regarding injury coding to your provider association or access the website at www.hcaiinfo.ca under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

Part 8 Prior and Concurrent Conditions

Part 8 Prior and Concurrent Conditions

☐ Additional sheets attached

a) 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 7?
☐ No ☐ Unknown ✓ Yes (please explain)

Periodic low back pain. Last episode March 2003.

If Yes to "a" 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)

Low back strain injury of March 2003 treated with heat therapy and gradual progression to an active exercise program. Home exercise and use of a lumbar support belt for lifting allowed return to modified work in June.

b) Since the accident, has the applicant developed any other disease, condition or injury not related to the automobile accident that could affect his/her response to treatment for the injuries identified in Part 7?
☐ No ☐ Unknown ✓ Yes (please explain)

Depression - sudden death of mother.

c) Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline?
☐ Yes ✓ No
If yes, please provide a complete explanation, in accordance with the PAF Guidelines, and with express reference to the provisions of the PAF Guidelines on which you rely, why this OCF-18 Treatment Plan is being submitted instead of a Pre-approved Framework Treatment Confirmation Form (OCF-23/198).

The information provided in this section helps the insurer to better understand the applicant's pre-accident status and informs the insurer of any pre-existing condition(s) that may affect the applicant's response to treatment. Provide relevant information 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. Additional sheets may be attached if necessary.

In Part 8 c), if you are proposing treatment for a condition for which there is a Pre-approved Framework, indicate why the Pre-approved Framework does not apply.

Part 9 Activity Limitations

Part 9 Activity Limitations

a) Does the applicant's impairment(s) from the injuries identified in Part 7 affect his/her ability to carry out:

His/her tasks of employment ☐ Not employed ☐ No ☐ Unknown ✓ Yes

His/her activities of normal life ☐ No ☐ Unknown ✓ Yes

b) If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function.

Maintaining and changing body position, lifting, carrying, driving, preparing meals, housework, shopping,

c) If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant?

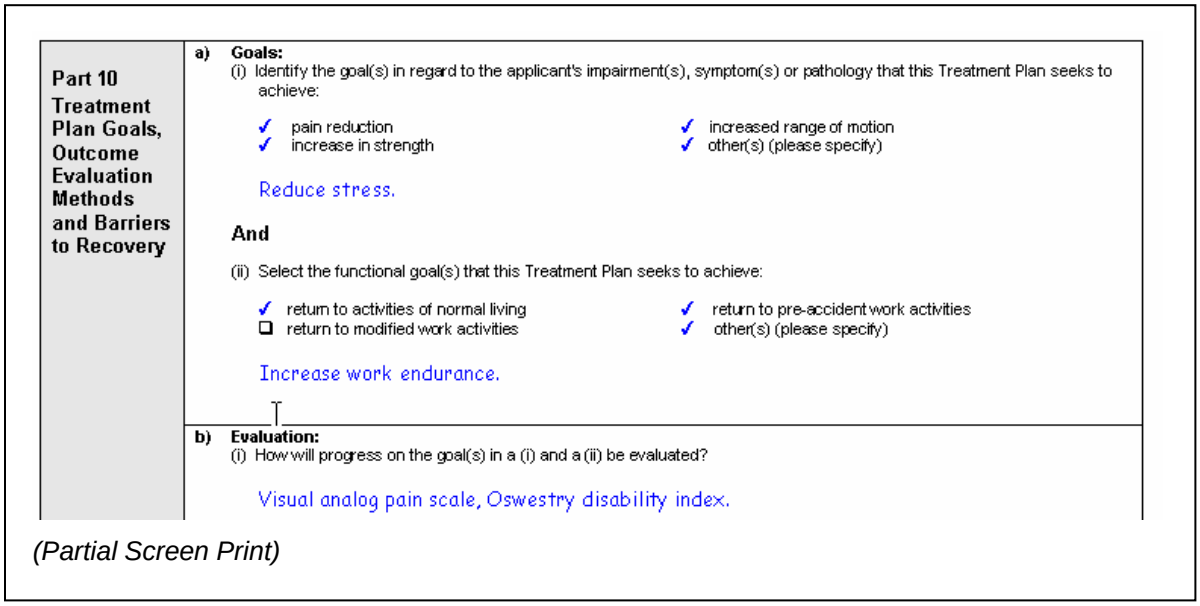
☐ Not employed ☐ Yes ☐ Unknown ✓ No (please explain)

Not available.

The responses are based on your current knowledge and information provided by the applicant. If any of the responses to the questions in section a) are "yes", provide a brief description of the activity limitations the applicant is experiencing.

A response of "no" in section c) requires further explanation and may require contacting the employer, but is not intended to signify the need for a job site assessment.

Part 10 Goals, Outcome Evaluation Methods and Barriers to Recovery



Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

a) Goals:
(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve:

- ✓ pain reduction
- ✓ increase in strength
- ✓ increased range of motion
- ✓ other(s) (please specify)

Reduce stress.

And

(ii) Select the functional goal(s) that this Treatment Plan seeks to achieve:

- ✓ return to activities of normal living
- ☐ return to modified work activities
- ✓ return to pre-accident work activities
- ✓ other(s) (please specify)

Increase work endurance.

b) Evaluation:
(i) How will progress on the goal(s) in a (i) and a (ii) be evaluated?

Visual analog pain scale, Oswestry disability index.

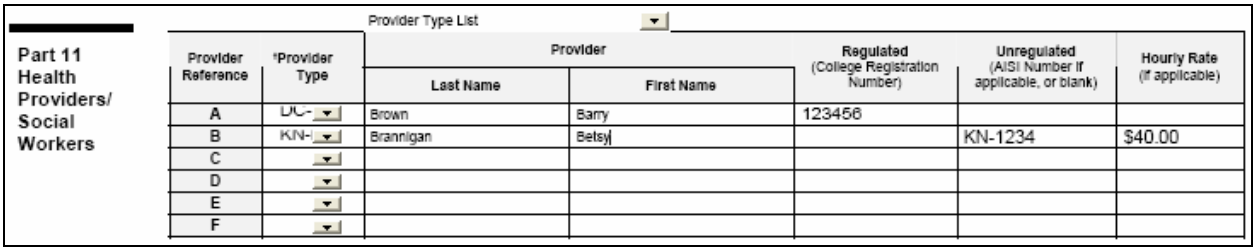
(Partial Screen Print)

This section is intended to outline the goals of treatment and how the health care provider will evaluate treatment progress. It also provides additional information around other barriers to recovery that are not indicated as a prior or concurrent condition, and informs the insurer of any concurrent treatment being provided to the patient.

In Part 10 e), indicate if you are aware of any applicable guidelines for this patient's condition. These may be clinical guidelines, Superintendent's guidelines, or other less formal guidelines.

Failure to list a guideline cannot in itself result in the denial of the Treatment Plan.

Part 11 Health Providers



Part 11 Health Providers/ Social Workers

Provider Type List

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	DC-	Brown	Barry	123456		
B	KN-	Brannigan	Betsy		KN-1234	$40.00
C						
D						
E						
F						

Health Providers and Social Workers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference is used to cross-reference information in Part 12 of the Treatment Plan and the Automobile Insurance Standard Invoice.

Assign a Provider Type code for each of the health professionals and social workers rendering services or prescribing goods.

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

If you are a regulated health professional, provide your college registration number and leave the AISI number blank. If you are an unregulated provider, you can obtain an AISI number by registering at www.hcaiinfo.ca.

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

If appropriate, enter the hourly billing rate for each of the providers listed. If you will not be billing for the proposed services using an hourly rate, enter N/A.

Part 12 Proposed Goods and Treatment Services

Part 12 Proposed Goods and Services

To the extent possible, this Treatment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility or Social Worker for the period of this Treatment Plan

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	†Measure	Cost	Total Count	Total Cost
1	Initial Assessment	2.ZZ.02		A	1.00	Pr	49.00	1	49.00
2	Claim Form (OCF-18)	7.SJ.30.LB		A	1	Pr	63.72	1	63.72
3	Manipulation	1.S1.72		B	1.00	Pr	15.00	12	180.00
4	Exercise Ball	G.XX.14		B	1.00	Gc	20.00	1	20.00
5	Exercise	1.ZZ.02		B	1.00	Hr	50.36	12	604.32
6									0.00
7									0.00
8									0.00
9									0.00
10									0.00
11									0.00
12									0.00
13									0.00
14									0.00
15									0.00
16									0.00

Estimated duration of this Treatment Plan:	8 weeks	Sub-Total:	27 917.04
How many treatment visits have you already provided:	visits	†Minus MOH:	0.00
		- Minus Other Insurer 1 + 2:	200.00
		GST (if applicable):	1.40
		PST (if applicable):	1.60
		Auto Insurer Total:	720.04

Note †: Refer to the User Manual at www.hcaiinfo.ca for coding.

Attributes codes are used to further qualify the service codes and are described in the manual.

Payment by auto insurer is secondary to available collateral benefits.

Please indicate any additional comments regarding proposed goods and services:

☐ additional sheets attached

*Refer to **Appendix C** for additional examples of Part 12 Proposed Goods and Treatment Services.*

Goods/Service Reference (G/S)

Assign a G/S reference number to each good or service you will be providing to the applicant. **Remember to use the same G/S reference number from the Treatment Plan when completing Version A of the Automobile Insurance Standard Invoice (OCF-21).**

Description

Enter a description of the good or service provided.

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 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 provider association or access the website at www.hcaiinfo.ca.

Provider Reference

Enter the Provider Reference code of the health professional or social worker who will render the service or is prescribing the good (from Part 11).

When a service is to be provided by more than one health care professional or social worker, enter all Provider Reference codes (separated by commas).

Estimate / Day

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 during each day of anticipated treatment.

- First, you need to enter the total quantity of the good or service that will be delivered during each visit or treatment day; 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*, *kilometres* of travel) for the quantity of service you are proposing to deliver each treatment day.
- Third, report the cost per service.

*Refer to **Appendix F** for valid Unit Measure Codes and a Conversion Table to convert minutes to hours.*

Projected Total Count

For each Good/Service Reference line, enter the total number of the good(s) or service(s) anticipated over the course of this treatment plan.

Projected Total Cost

For each Good/Service Reference line, enter the total cost of the good(s) or service(s) anticipated over the course of this treatment plan. It is calculated by multiplying cost by projected total count.

Sub-Total Count

The sub-total of Total Count is the sum of all counts of all goods and services to be rendered under this treatment plan. It is calculated by summing the Projected Total Count column.

Sub-Total Cost

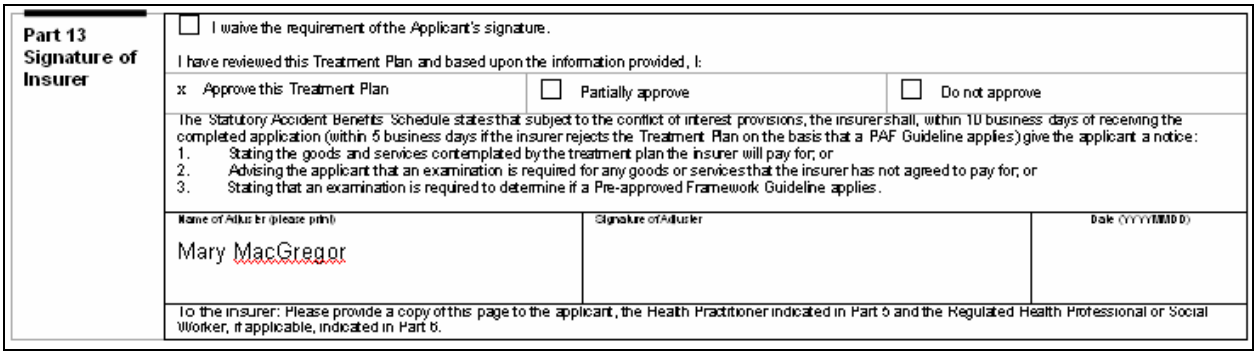
The sub-total of Total Cost is the sum of all costs for all goods and services to be rendered under this treatment plan. It is calculated by summing the Projected Total Cost column.

Totals

In the Totals section:

- **Sub-Total** is the sum of the cost of all goods and services included in this treatment plan.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts that are payable to you for any of the goods and services listed above; this is subtracted from the sub-total.
- **Other Insurer 1 + 2** is the sum of all amounts payable to you from other insurers; this is also subtracted from the sub-total.
- **GST** is the total GST for all goods and services listed above.
- **PST** is the total PST for all goods and services listed above.
- **Auto Insurer Total** is the sum of all amounts in this section.

Part 13 Signature of Insurer



Part 13 Signature of Insurer

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

I have reviewed this Treatment Plan and based upon the information provided, I:

x Approve this Treatment Plan ☐ Partially approve ☐ Do not approve

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 10 business days of receiving the completed application (within 5 business days if the insurer rejects the Treatment Plan on the basis that a PAF Guideline applies) give the applicant a notice:

1. Stating the goods and services contemplated by the treatment plan the insurer will pay for; or
2. Advising the applicant that an examination is required for any goods or services that the insurer has not agreed to pay for; or
3. Stating that an examination is required to determine if a Pre-approved Framework Guideline applies.

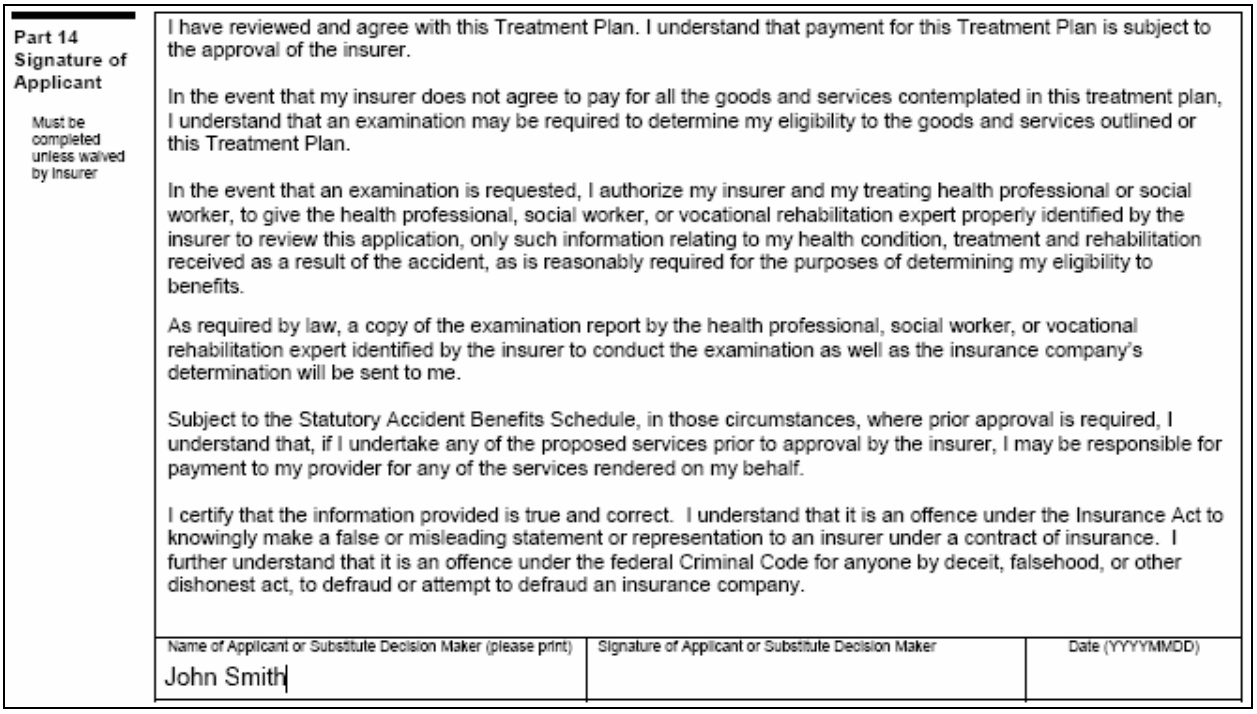
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
Mary MacGregor		

To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 5 and the Regulated Health Professional or Social Worker, if applicable, indicated in Part 6.

The insurer will complete Part 13 and return page 5 to the applicant and the health practitioner indicated in Part 5. The health practitioner should contact each of the health professionals and social workers listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.

If the insurer partially approves or does not approve the treatment, they must provide an explanation as to why the treatment plan has been declined.

Part 14 Signature of Applicant



Part 14 Signature of Applicant

Must be completed unless waived by Insurer

I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer.

In the event that my insurer does not agree to pay for all the goods and services contemplated in this treatment plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment Plan.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

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.

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

After you have reviewed the treatment plan with the applicant, the applicant or the applicant's Substitute Decision Maker, as defined in the *Substitute Decisions Act*, must sign here. The insurer may elect to waive the requirement of the applicant signature, but this must 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 and their obligations, please refer him/her to their insurance claims adjuster.