

# **OCF 21 - AUTO INSURANCE STANDARD INVOICE**

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## **USER MANUAL**

**March 2006**

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## Document Change History

Date	Description of Change	Reason
20030930	Initial Publication	
20031215	Invoicing for PAF Extension Visits (PW2EV)	
20040204	Clarify Payee Facility Number and Payee Number	
20050214	Revised Payee Information	For consistency with revised OCF forms 01/Dec/04
<u>20060301</u>	<u>Revised Further information, Who Completes this Form, Invoice Information</u>	<u>Redirects users to HCAI website for further information and reflects removal of DACs and inclusion of social worker.</u>

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-21 Auto Insurance Standard Invoice. Other manuals are available to assist in the completion of:

- OCF-3**            Disability Certificate
- OCF-18**        Treatment Plan
- 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 Auto Insurance Standard Invoice 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)<sup>1</sup>, to identify injuries and the *Canadian Classification of Health Interventions* (CCI)<sup>1</sup> to classify health care services and procedures.

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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.

### ***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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>User Manuals.

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-21 Automobile Insurance Standard Invoice**

### ***Background***

The Automobile Insurance Standard Invoice, AISI, is to be used when billing automobile insurers for medical and rehabilitation goods and services, assessments and examinations. It is used for accidents that occur on or after November 1, 1996. Any health care provider billing an Ontario automobile insurer to treat the victim of a motor vehicle accident for benefits under the Statutory Accident Benefits Schedule of the *Insurance Act* should use this form.

The Standard Invoice was devised to provide more efficient processing of invoices, better information about medical and rehabilitation health services being provided, and increased accountability in the automobile insurance sector. There are three distinct versions for the standard invoice: A, B and C. The circumstances under which each version must be used are set out below.

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 to use Version A?***

You can use Version A *only* where an auto insurer has approved the goods and services that are being billed. Insurer approval is requested using the following forms:

- a Treatment Plan (OCF-18),
- a Designated Assessment Centre Referral, Plan and Summary Form (OCF-11),
- an Application for Approval of an Assessment or Examination (OCF-22/198).

Since the approved plan has already described the injury, health provider and goods and services information, there is no need to duplicate that information. Version A works in conjunction with the approved plan to indicate services provided and remuneration owing.

### ***When to use Version B?***

Version B *must* be used when billing an auto insurer for goods or services that have *not* been previously approved. It may not be used for billing Pre-approved Frameworks (use Version C). Version B requires the provider to describe all the injury, health provider and goods and services information.

Providers have the option of using either Version A or B if an OCF-18 (Treatment Plan), OCF-11 (DAC Assessment Plan), or OCF-22 (Application for Approval of an Assessment or Examination) has been approved.

### ***When to use Version C?***

Version C *must* be used when billing for services rendered through a Pre-approved Framework. This includes billing for PAF Extension Visits approved by the insurer on an OCF-24.

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

The Applicant or Substitute Decision Maker completes Parts 1 and 2. The remaining invoice can be completed by the health care provider, social worker or by the individual responsible for the facility billing. The health care provider or their authorized signatory must sign Part 4.

## Fee

There is no fee associated with the completion of the Standard Invoice.

Return this form to:	<b>Auto Insurance Standard Invoice (OCF-21)</b> <small>Use this form for accidents that occur on or after November 1, 1998</small>
ABC Insurance Company P.O. Box 123, Station 'A' Toronto, ON M1M 1M1 Attn: Mary MacGregor	Claim Number: 1234567-001
	Policy Number: 9876543
	Date of Accident: (yyyymmdd) 20031001

## 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.

## Part 1 Applicant information

<b>Part 1 Applicant Information</b>  To be completed by the applicant	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 Jonathan		Middle Name James	
	Address 123 Main Street			
City Toronto		Province ON	Postal Code M9M 9M9	

**If this is a second or subsequent invoice**, you do not have to fill out all fields of this section. Provide only the full name and date of birth. If an applicant's address has changed, provide the new address.

## Part 2 Insurance Company Information

<b>Part 2 Insurance Company Information</b>	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: <input type="checkbox"/> Applicant OR		Policy Holder Last Name Smith	Policy Holder First Name Jessica	

This is the name of the insurance company and branch responsible for processing and paying the invoice. Completing the adjuster information fields, if known, will assist insurers to process the invoice more quickly. The name of the **Policyholder** will assist insurers to match the accident with the policy, thus ensuring quick processing of the invoice.

## Part 3 Invoice information

<b>Part 3 Invoice Information</b>	For <b>previously approved goods and services</b> , please complete the following:										
	Type of Plan or Pre-approved Framework		Plan Date (YYYYMMDD)	Plan Number	Approved Amount	Previously Billed					
	<input checked="" type="checkbox"/> Treatment Plan (OCF-18) ♦		2006 03 0	01	\$490.50	\$0.00					
	<input type="checkbox"/> Assessment Plan (OCF-22) ♦										
	<input type="checkbox"/> PAF Type: ▼ ▲										
<table border="1"> <tr> <td>Invoice Number</td> <td>CCR - 9042</td> </tr> <tr> <td>First Invoice</td> <td><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Last Invoice</td> <td><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>		Invoice Number	CCR - 9042	First Invoice	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Last Invoice	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	♦ Attach Version A or B ▲ Attach Version C For all other invoices, attach Version B			
Invoice Number	CCR - 9042										
First Invoice	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
Last Invoice	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										

**Invoice number** is the space for your own internal invoice number. It is optional.

Indicate that this is a **First Invoice**, if you are beginning to treat this applicant for injuries sustained in a new motor vehicle accident or in relation to a new Treatment Plan.

Indicate "Yes" to the **Last Invoice** question, if the applicant has been discharged.

If the invoice is for pre-approved services, please check the appropriate type of plan or PAF and indicate the date and number of the plan.

## Part 4 Payee Information

<b>Part 4 Payee Information</b>	Facility Name (if applicable) Family Care Clinic		AISI Facility Number (if applicable) T2222		
	Payee Last Name Berrington		Payee First Name Belinda	Payee Number (if applicable) 654321	
	Address 234 Second Avenue East				
	City Toronto	Province ON	Postal Code M2M 2M2		
	Telephone Number (416) 555-5555	Extension 2424	Fax Number (416) 556-5555		
	Email Address bberrington@famcare.ca				
	<input checked="" type="checkbox"/> 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 this invoice. Or <input type="checkbox"/> I am declaring the following conflicts of interest relating to this invoice:				
	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 and costs of goods and services that are provided to automobile accident victims, by health care providers; preventing fraud and detecting fraud where there are reasonable grounds to suspect fraud.				
	Name of Health Professional Social Worker or Authorized Signatory (please print) Belinda Berrington		Signature of Health Professional Social Worker or Authorized Signatory	Date (YYYYMMDD)	

Full mailing address and other contact information must be completed.

### AISI Facility Number

AISI Facility Numbers are required for facilities and unregulated professionals but not regulated health professionals. You can obtain an AISI Facility Number by registering at [www.hcaiinfo.ca](http://www.hcaiinfo.ca). If you already have an AISI Facility Number, you do not need to register again for the new invoice. Regulated Health Professionals may also register for an AISI Facility Number, although it is not mandatory. Enter your AISI Facility Number in this field (e.g., T---). If you are a regulated health professional and have not registered, leave the field blank.

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

### Payee Number

If you are a regulated health professional, enter your college registration number here. Unregulated providers must obtain an AISI provider registration number by registering at [www.hcaiinfo.ca](http://www.hcaiinfo.ca). Providers that already have an AISI Provider Number do not need to register again for the new invoice. Unregulated providers enter the AISI Provider Number in this field.

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

### Conflict of Interest and Signature of Health Professional

Read the Conflict of Interest statement and check the appropriate box.

### Signature of Health Professional (Authorized Facility Signatory)

If the invoice is submitted by a regulated health professional or social worker, the regulated health professional or social worker provides the signature. When unregulated providers/facilities register, they indicate who is authorized to submit invoices on behalf of the facility.



The inclusion of a revised statement of understanding identifies for the Health Professional or Social Worker the range of specific uses that will be made of information related to providing services to injured auto insurance claimants

## Version A

You can use Version A only when billing for goods and services that have been requested and approved through an OCF-18, OCF-22, or OCF-11. Injuries, providers, goods and services are detailed on the plan; there is no need to duplicate that information on Version A. If you wish, you can choose to use Version B for goods and services that the insurer has already approved following submission of one of the forms named above.

### **Injury and Sequelae Information**

Injuries and Sequelae	
Description	ICD Code
Sprain and strain of lumbar spine	S33.5
Headaches	G44
Injury details are not required if they are the same as those on a previously approved plan. *Refer to the User Manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for coding.	

**Injuries need only be entered if there has been a change in the injuries/sequelae and no change to the planned goods and services since the plan was approved.**

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.

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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

## Providers

Provider Type List		Providers					
Ref	Type	Last Name	First Name	Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
A	PT - PR	Berrington	Belinda	654321		\$60.00	
B	KN - KP	Brannigan	Deby		KN-1234	\$40.00	
C							
D							
E							
F							

Provider details are not required if they are the same as those on an approved plan.  
 \* Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for coding.

**Providers need only be entered if there has been a change in the providers since the plan was approved.**

Health providers/Social workers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference letters are used to cross-reference information on previously approved plans 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.

If you are a regulated health professional or social worker, 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](http://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.

The box for Insurer Use may be used by insurers to total goods and services by Provider Type for statistical reporting.

## Goods and Services

Each calendar page represents one month of goods or services rendered. Column headings 1 through 31 across the top of the table represent the dates of service from the first of the month to the thirty-first of the month. If you are invoicing for goods or services which span across 2 months, complete one Version A for each calendar month. Totals need to be calculated on only the last calendar page.

Details of the good or service (descriptions and CCI/GAP codes) are not required on Version A. These are already provided on the approved plan. You need only enter the Goods/Service Reference number from column 1 of the approved plan in the first column of the calendar table.

For each date a good or service was rendered, indicate the reference number of the Provider (column 1 from the Provider Table -- A or B or C, etc.) who rendered the service or prescribed the good.

### Goods/Service Reference

Enter the goods and services reference number from the previously approved plan (e.g., 1, 2, 3).

Example from an approved Treatment Plan OCF-18

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 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	.75	hr	45.00	1	45.00
2	Claim Form (OCF-18)	7.SJ.30.LB		A	1	pr	42.50	1	42.50
3	Mobilization	1.S1.01		A	.25	hr	15.00	12	180.00
4	Exercise Ball	G.XX.14		B	1	gd	20.00	1	20.00
									00.00

Example from corresponding Standard Invoice OCF-21A

*G/S Ref	Month (yyyy-mm): 2003-10																G S T	P S T	Cost/Day	Total Count	Total Cost
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16					
1						A													45.00	1	45.00
2						A													42.50	1	42.50
3							A		A			A	A						15.00	4	60.00
4												B						✓	20.00	1	20.00
5												B	B						25.00	2	50.00
																				9	217.50

### Month (yyyy-mm)

Enter the month the services or goods were rendered in the format yyyy-mm (e.g., 2003-11). Each calendar page represents one month. Additional pages can be used for additional months.

### Provider

Enter in the grid the provider reference letter (e.g., A, B, C) of the individual who rendered the service or prescribed the good under the appropriate dates. The only entries that should appear on the calendar are upper case alphabetic letters.

## GST and PST

The only valid entry in the GST and PST columns is blank (does not apply) or a check mark (applies). Amounts associated with GST and PST are indicated as totals and are not required at the detail level.

## Cost / Day

All goods or services on a single row must have the same cost per day. Enter the cost per day in this column (e.g., \$20.00 for a 1/2 hour service each day).

If a service or good has a different cost per day it must be entered as a second row with the same G/S Reference number (e.g., \$40.00 for a 1 hour service for each day).

## Total Count / Service

The Total Count is a count of all dates when this good or service was prescribed or rendered at the cost indicated for this row. If 6 therapy sessions are indicated for this row in the calendar, Total Count is 6.

## Total Cost / Service

The Total Cost column for each row is equal to Cost/Day times Total Count (i.e., the total for this service or good at this rate for the month).

## Sub-Total Count

The sub-total of Total Count is the sum of all counts of all goods and services rendered for the month. It is calculated by summing the Total Count column and should be equal to the number of calendar dates of service with a provider in the box.

## Sub-Total Cost

The sub-total of Total Cost is the sum of all costs for all goods and services rendered for the month. It is calculated by summing the Total Cost column and should be equal to the cost of all goods and services by all providers for all dates of service for the month.

## **Other Insurance Amounts**

Other Insurance (for goods and services on this invoice)		MOH	Insurer 1	Insurer 2
	Chiropractic:			
	Physiotherapy:		-100.00	
	MassageTherapy:			
	<sup>1</sup> Other Service Type:			
	<b>Total:</b>	0.00	-100.00	0.00
<sup>1</sup> Please Specify Other Service Type:				

Enter the total amounts received or estimated to be payable to you on this invoice for goods and services from other insurance sources (e.g., Ministry of Health and Long-Term Care and Extended Health Care plans to which the applicant is eligible).

Categorize amounts by Chiropractic, Physiotherapy, Massage Therapy, and Other. When the category "Other" is used, specify the type of services covered (e.g., dental, psychological, optometric).

Amounts may be signed (+/-) or unsigned. When you are indicating the amount payable or not payable from an Other Insurer:

- Use a negative sign (-) to indicate the amount you have received or will receive directly from the collateral source or applicant. This will allow collateral insurance payments to be subtracted from the sub-total to determine the amount owed by the automobile insurer.
- Use a positive sign (+) or leave unsigned to indicate the amount previously identified for payment by another insurer but subsequently ruled ineligible. This will allow you to add the unpaid amount to the auto insurer's invoice.

### **Account Activity Since Last Invoice**

<b>Account Activity Since Last Invoice</b> (if Interest is being charged)	
Prior Balance:	<b>120.50</b>
Payment Received from Auto Insurer:	<b>0.00</b>
<sup>2</sup> Overdue Amount:	<b>120.50</b>
<small>*The insurer shall pay interest on overdue outstanding balances in accordance with the Statutory Accident Benefits Schedule.</small>	

This section is required only if you are charging interest on this invoice.

It provides details on Overdue Amounts which are the basis for Interest charges. Enter Prior Balance (the "Auto Insurer Total" from your last invoice) and subtract Payments Received since your last invoice to calculate Overdue Amount.

**Totals**

<b>Sub-Total:</b>	217.50
<b>MOH:</b>	0.00
<b>Other Insurer 1 + 2:</b>	-100.00
<b>GST (if applicable):</b>	1.40
<b>PST (if applicable):</b>	1.60
<b><sup>2</sup>Interest:</b>	2.41
<b>Auto Insurer Total:</b>	122.91

In the Totals section:

- **Sub-Total** is the sum of the cost of all goods and services included on all pages of this invoice.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts. This amount is taken from the “Other Insurance” amounts table, column 1 (MOH). Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
- **Other Insurer 1 + 2** is the sum of all amounts received or payable to you from other insurers. This amount is taken from the “Other Insurance” amounts table, column 2 + column 3. Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
- **GST** is the total GST for all goods and services included in this invoice. Goods and services to which GST applies are identified with a check mark in the GST column.
- **PST** is the total PST for all goods and services included in this invoice. Goods and services to which PST applies are identified with a check mark in the PST column.
- **Interest** is the total amount due for overdue outstanding balances and is based on the Overdue Amount calculated in the section: “Account Activity Since Last Invoice.” Interest is calculated in accordance with the Statutory Accident Benefits Schedule.
- **Auto Insurer Total** is the sum of all amounts in this section.

Make cheque payable to:	
Other Information:	

***Make cheque payable to***

Enter the name of the facility, clinic, or person to whom the cheque should be made payable.

***Other Information***

This space may be used to communicate any additional information that will help the insurer process the invoice.

***For Insurer Use***

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

This table is provided for insurers' review, approval, and payment processes and to assist with communication with accounting functions. The grand total is broken down to allow sub-ledgering of interest separately from medical payments.

## Version B

Version B must be used when billing an auto insurer for goods or services that have not been previously approved. It may not be used for billing Pre-approved Frameworks (use Version C). Version B requires the provider to describe all the injury, health provider and goods and services information.

Providers have the option of using either Version A or B if an OCF-18 (Treatment Plan), OCF-11 (DAC Assessment Plan), or OCF-22 (Application for Approval of an Assessment or Examination) has been approved.

### **Injury and Sequelae Information**

#### 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 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	ICD Code
Sprain and strain of lumbar spine	S33.5
Headaches	G44
Injury details are not required if they are the same as those on a previously approved plan. *Refer to the User Manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for coding.	

Injuries must be entered if:

- i) no plan has been submitted,
- ii) the plan has not been approved, or
- iii) there has been a change in the injuries/sequelae since the plan was approved.

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.

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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.



## **Providers**

Provider Type List		Providers		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name	First Name				
A	PT - PR	Berrington	Beinda	654321		\$60.00	
B	KN - KR	Brannigan	Betsy		KN-1234	\$40.00	
C							
D							
E							
F							

Provider details are not required if they are the same as those on an approved plan.  
 \* Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for coding.

Providers must be entered if:

- i) no plan has been submitted, or
- ii) the plan has not been approved, or
- iii) there has been a change in the providers since the plan was approved.

Health providers/Social Workers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference letters are used to cross-reference information on previously approved plans 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.**

If you are a regulated health professional or social worker, 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](http://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.

The box for Insurer Use may be used by insurers to total goods and services by Provider Type for statistical reporting.

## Goods and Services

Date of Service			Description	Code	Attribute	Provider Reference	Quantity	Measure	GST (4)	P&T (4)	Cost		
YYYY	MM	DD											
2008	1	15	Initial Assessment	2.ZZ.02			0.75				45.00		
2008	1	15	Claim Form (OCF-18)	7.SJ.30.LB			1.00				42.50		
2008	1	15	Mobilization	1.S1.01			0.25				15.00		
2008	1	15	Mobilization	1.S1.01			0.25				15.00		
2008	1	15	Mobilization	1.S1.01			0.25				15.00		
2008	1	15	Exercise Ball	G.XX.14			1.00		✓	✓	20.00		
2008	1	15	Exercise	1.ZZ.02	GR		1.00				25.00		
2008	1	15	Mobilization	1.S1.01			0.25				15.00		
2008	1	15	Exercise	1.ZZ.02	GR		1.00				25.00		
*Refer to the User Manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for coding.									<b>Sub-Total</b>		1.40	1.60	217.50

Refer to **Appendix B** for additional examples of this section of the invoice

### Date of Service

Enter the date the good or service was rendered in the format year, month, day (e.g., 2003-11-15).

### Description

Enter a brief 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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

### Provider Reference

Enter the Provider Reference code of the professional rendering the service or prescribing the good.

When a service is provided by more than one health care professional or social worker, enter all Provider Reference codes (separated by commas) and add the appropriate Attribute Code (e.g., IM - individual with more than one provider).

## Unit (Quantity and Measure)

Enter a number and the unit of measure to indicate the quantity of goods or services rendered on a single date of service. For time-based services, the unit of measure is an hour. Any portion of an hour is entered as a decimal (e.g., 15 minutes is represented as .25 Hr). For procedure-based services, the unit of measure is a procedure and is always a whole number (e.g., a chiropractic manipulation is represented as 1 Pr).

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

## GST and PST

The only valid entry in the GST and PST columns is blank (does not apply) or a check mark (applies). Amounts associated with GST and PST are indicated as totals and are not required at the detail level.

## Cost

Enter the cost of the good or service for the specified date.

## Sub-Total

Enter the sum of all costs on this page.

If more pages are required, duplicate page 2 only, and indicate the sub-total at the bottom of each page.

## Other Insurance Information

<b>OCF-21 - Version B (page 3)</b>	
<small>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 (see Version C - pages 2 and 3).</small>	
<b>OTHER INSURANCE:</b> I have made reasonable enquiries of the claimant 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 goods and services included in this invoice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable
Other Insurer 1	Other Insurer Name <b>XYZ Life Insurance Company</b>
	Other Insurer's Identifier <b>401-123-321</b>
Other Insurer 2	Other Insurer Name
	Other Insurer's Identifier
<small>Other insurance details are not required if they are the same as those on a pre-approved plan.</small>	

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 goods or services provided are 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.

This information is not required on Version A as you have already provided it in the approved plan. It may be left blank on Version B if you have already completed it on the approved plan and have elected to use Version B for invoicing.

**Conflict of Interest Definition**

Conflict of Interest Definition
<p>A person has a conflict of interest relating to an invoice if:</p> <ul style="list-style-type: none"> <li>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 the goods or services, and</li> <li>ii) the person who may receive the financial benefits 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.</li> </ul>

Determine if you have a conflict of interest relating to this invoice. Refer any questions to your college or association.

**Other Insurance Amounts**

Other Insurance (for goods and services on this invoice)	MOH	Insurer 1	Insurer 2
Chiropractic:			
Physiotherapy:		-100.00	
Massage Therapy:			
<sup>1</sup> Other Service Type:			
<b>Total:</b>	<b>0.00</b>	<b>-100.00</b>	<b>0.00</b>
<sup>1</sup> Please Specify Other Service Type:			

Enter the total amounts received or estimated to be payable to you on this invoice for goods and services from other insurance sources (e.g., Ministry of Health and Long-Term Care and Extended Health Care plans to which the applicant is eligible).

Categorize amounts by Chiropractic, Physiotherapy, Massage Therapy, and Other. When the category "Other" is used, specify the type of services covered (e.g., dental, psychological, optometric).

Amounts may be signed (+/-) or unsigned. When you are indicating the amount payable or not payable from an Other Insurer:

- Use a negative sign (-) to indicate the amount you have received or will receive directly from the collateral source or applicant. This will allow collateral insurance payments to be subtracted from the sub-total to determine the amount owed by the automobile insurer.
- Use a positive sign (+) or leave unsigned to indicate the amount previously identified for payment by another insurer but subsequently ruled ineligible. This will allow you to add the unpaid amount to the auto insurer's invoice.

### **Account Activity Since Last Invoice**

<b>Account Activity Since Last Invoice</b> (if Interest is being charged)	
Prior Balance:	<b>120.50</b>
Payment Received from Auto Insurer:	<b>0.00</b>
<sup>2</sup> Overdue Amount:	<b>120.50</b>
<small>*The insurer shall pay interest on overdue outstanding balances in accordance with the Statutory Accident Benefits Schedule.</small>	

This section is required only if you are charging interest on this invoice.

It provides details on Overdue Amounts which are the basis for Interest charges. Enter Prior Balance (the "Auto Insurer Total" from your last invoice) and subtract Payments Received since your last invoice to calculate Overdue Amount.

**Totals**

<b>Sub-Total:</b>	217.50
<b>MOH:</b>	0.00
<b>Other Insurer 1 + 2:</b>	-100.00
<b>GST (if applicable):</b>	1.40
<b>PST (if applicable):</b>	1.60
<b><sup>2</sup>Interest:</b>	2.41
<b>Auto Insurer Total:</b>	122.91

In the Totals section:

- **Sub-Total** is the sum of the cost of all goods and services included on all pages of this invoice.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts. This amount is taken from the “Other Insurance” amounts table, column 1 (MOH). Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
- **Other Insurer 1 + 2** is the sum of all amounts received or payable to you from other insurers. This amount is taken from the “Other Insurance” amounts table, column 2 + column 3. Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
- **GST** is the total GST for all goods and services included in this invoice. Goods and services to which GST applies are identified with a check mark in the GST column.
- **PST** is the total PST for all goods and services included in this invoice. Goods and services to which PST applies are identified with a check mark in the PST column.
- **Interest** is the total amount due for overdue outstanding balances and is based on the Overdue Amount calculated in the section: “Account Activity Since Last Invoice.” Interest is calculated in accordance with the Statutory Accident Benefits Schedule.
- **Auto Insurer Total** is the sum of all amounts in this section.

Make cheque payable to:	Family Care Clinic
Other Information:	

***Make cheque payable to***

Enter the name of the facility, clinic, or person to whom the cheque should be made payable.

***Other Information***

This space may be used to communicate any additional information that will help the insurer process the invoice.

***For Insurer Use***

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

This table is provided for insurers' review, approval, and payment processes and to assist with communication with accounting functions. The grand total is broken down to allow sub-ledgering of interest separately from medical payments.

## Version C

Version C must be used only when billing for services rendered through a Pre-approved Framework.

### **Injury and Sequelae Information**

Injuries and Sequelae	
Description	ICD Code
Whiplash (WAD 2)	S13.41
Strain and sprain of lumbar spine	S33.5
Headaches	G44
Injury details are not required if they are the same as those on the Pre-approved Framework Treatment Confirmation Form (OCF-23/198) *Refer to the User Manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for coding.	

**Injuries need only be entered if there has been a change in the injuries/sequelae and no change to the planned goods and services since the Pre-approved Treatment Confirmation Form (OCF-23/198) was submitted.**

Provide a brief description of the injury and the corresponding injury code (ICD-10-CA code). List the PAF injury first. Up to six injuries/sequelae may be entered including the description and a valid ICD-10-CA code.

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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.



## **Health Providers**

Provider Type List		Providers		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name	First Name				
A	EC - CR	Brown	Barry	123456			
B	KN - KN	Brannigan	Betsy		Kn-1234		
C	OT - OX	Bloom	Bob	23456		\$84.00	
D							
E							
F							

\* Refer to the User Manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for coding.

The amounts shown in the example for the Block 1 and 2 fees and OT hourly fee are accurate from November 1, 2003 until further notice. For the period October 1 - October 31, 2003 inclusive, these amounts are: Block 1 fee - \$300; Block 2 fee - \$540; OT hourly rate - \$120.

Providers must be entered.

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 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.**

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](http://www.hcaiinfo.ca).

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

Since hourly rates are generally not applicable to Pre-approved Frameworks, enter N/A (not applicable). The exception to this is the Activities of Normal Living Intervention (ANLI), for which the hourly rate of the provider must be entered.

The box for Insurer Use may be used by insurers to total goods and services by Provider Type for statistical reporting.

**Goods and Services Rendered**

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)									
Date of Service			Description	*Code	*Attribute	Provider Reference	Quantity	*Measure	
YYYY	MM	DD							
2003	10	06	Initial Assessment	2.ZZ.02		A	1	pr	
2003	10	06	X-ray cervical spine	3.SC.10	CXB	A	1	pr	
2003	10	08	Manipulation	1.S1.72		A	1	pr	
2003	10	10	Manipulation	1.S1.72		A	1	pr	
2003	10	13	Manipulation	1.S1.72		A	1	pr	
2003	10	13	Exercise	1.ZZ.02	GR	B	1	hr	
2003	10	15	Manipulation	1.S1.72		A	1	pr	
2003	10	15	Exercise	1.ZZ.02	GR	B	1	hr	

Providers are required to declare the information requested on every treatment, service and good delivered. Failure to provide this information may delay payment.

**Date of Service**

Enter the date the good or service was rendered in the format year, month, day (e.g., 2003-11-15).

**Description**

Enter a brief 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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

**Provider Reference**

Enter the Provider Reference code of the professional rendering the service or prescribing the good.

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

## Quantity and Measure

Enter a number and the unit of measure to indicate the quantity of goods or services rendered on a single date of service. For time-based services, the unit of measure is an hour. Any portion of an hour is entered as a decimal (e.g., 15 minutes is represented as .25 Hr). For procedure-based services, the unit of measure is a procedure and is always a whole number (e.g., a chiropractic manipulation is represented as 1 Pr).

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

## Reimbursable Fees Within the PAF Guidelines

Reimbursable Fees Within the PAF Guidelines:			
Description	'Code	'Attribute	Cost
PAF WAD II Block Fee 1	P.W2.B1		240.00
X-Rays Cervical Spine	3.SC.10	CXB	42.00
PAF WAD II Block Fee 2	P.W2.B2		432.00
Supplemental Goods and/or Services	P.W2.SC		40.00
*Refer to the User Manual at <a href="http://www.hcalinfo.ca">www.hcalinfo.ca</a> for coding.		PAF Fee Totals:	754.00

The amounts shown in the example for the Block 1 and 2 fees and OT hourly fee are accurate from November 1, 2003 until further notice. For the period October 1 - October 31, 2003 inclusive, these amounts are: Block 1 fee - \$300; Block 2 fee - \$540; OT hourly rate - \$120.

Use this box to record fees that are pre-approved in the relevant PAF Guideline.

## Description, Code, and Attribute

Enter a description and code of the reimbursable service. Attribute codes in this section are required for all radiology codes.

Refer to **Appendix D** for a complete list of PAF block codes.

## Cost

Enter the appropriate cost according to the Pre-approved Framework Guideline.

## Other Reimbursable Goods and Services Approved by the Insurer

Other Reimbursable Goods and Services Approved by the Insurer:											
Date of Service			Description	Code	Attribute	Provider Reference	Quantity	Measure	GST (4)	PST (4)	Cost
YYYY	MM	DD									
200			ANLI	P.W2.AN		C	3.00	Hr			262.00
200				A.XX.TT		C	0.33	Hr			28.00
200				A.XX.KM		C	50.00	Km			13.75
*Refer to the User Manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for coding.										Other Goods and Services Total:	293.75

The amounts shown in example for the Block 1 and 2 fees and OT hourly fee are accurate from November 1, 2003 until further notice. For the period October 1 - October 31, 2003 inclusive, these amounts are: Block 1 fee - \$300; Block 2 fee - \$540; OT hourly rate - \$120.

Use this box to record fees for services permitted by the relevant PAF Guideline, but which require insurer approval. This includes fees for PAF Extension Visits approved by the insurer on an OCF-24. Enter one line for each date of service using the code P.W2.EV with a quantity and measure of 1 sn (session). Use page 2, to itemize the services rendered for each visit.

### Date of Service

Enter the date the good or service was rendered in the format year, month, day (e.g., 2003-11-15).

### Description

Enter a brief 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](http://www.hcaiinfo.ca) under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

### Provider Reference

Enter the Provider Reference code of the professional rendering the service or prescribing the good.

When a service is provided by more than one health care professional, enter all Provider Reference codes separated by commas.

## Quantity and Measure

Enter a number and the unit of measure to indicate the quantity of goods or services rendered on a single date of service. For time-based services, the unit of measure is an hour. Any portion of an hour is entered as a decimal (e.g., 15 minutes is represented as .25 Hr). For procedure-based services, the unit of measure is a procedure and is always a whole number (e.g., a chiropractic manipulation is represented as 1 Pr).

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

## GST and PST

The only valid entry in the GST and PST columns is blank (does not apply) or a check mark  (applies). Amounts associated with GST and PST are indicated as totals and are not required at the detail line level.

## Cost

Enter the cost of the good or service for the specified date.

## Other Goods and Services Total

Enter the sum of all costs in this section.

## Other Insurance Amounts

Other Insurance (for goods and services on this invoice)		MOH	Insurer 1	Insurer 2
	Chiropractic:	-50.35		
	Physiotherapy:		-100.00	
	Massage Therapy:			
	<sup>1</sup> Other Service Type:			
	<b>Total:</b>	-50.35	-100.00	0.00
<sup>1</sup> Please Specify Other Service Type:				

Enter the total amounts received or estimated to be payable to you on this invoice for goods and services from other insurance sources (e.g., Ministry of Health and Long-Term Care and Extended Health Care plans to which the applicant is eligible).

Categorize amounts by Chiropractic, Physiotherapy, Massage Therapy, and Other. When the category "Other" is used, specify the type of services covered (e.g., dental, psychological, optometric).

Amounts may be signed (+/-) or unsigned. When you are indicating the amount payable or not payable from an Other Insurer:

- Use a negative sign (-) to indicate the amount you have received or will receive directly from the collateral source or applicant. This will allow collateral insurance payments to be subtracted from the sub-total to determine the amount owed by the automobile insurer.
- Use a positive sign (+) or leave unsigned to indicate the amount previously identified for payment by another insurer but subsequently ruled ineligible. This will allow you to add the unpaid amount to the auto insurer's invoice.

### Account Activity Since Last Invoice

Account Activity Since Last Invoice (if Interest is being charged)	
Prior Balance:	0.00
Payment Received from Auto Insurer:	0.00
<sup>2</sup> Overdue Amount:	0.00
<small>*The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.</small>	

This section is required only if you are charging interest on this invoice.

It provides details on Overdue Amounts which are the basis for Interest charges. Enter Prior Balance (the "Auto Insurer Total" from your last invoice) and subtract Payments Received since your last invoice to calculate Overdue Amount.

### Totals

Sub-Total:	1,047.75
MOH:	-50.35
Other Insurer 1 + 2:	-100.00
GST (if applicable):	2.80
PST (if applicable):	3.20
<sup>2</sup> Interest:	N/A
<b>Auto Insurer Total:</b>	<b>903.40</b>

In the Totals section:

- **Sub-Total** is the sum of the cost of all goods and services included on all pages of this invoice.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts. This amount is taken from the "Other Insurance" amounts table, column 1 (MOH). Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer's invoice.
- **Other Insurer 1 + 2** is the sum of all amounts received or payable to you from other insurers. This amount is taken from the "Other Insurance" amounts table, column 2 + column 3. Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer's invoice.

- **GST** is the total GST for all goods and services included in this invoice. Goods and services to which GST applies are identified with a check mark in the GST column.
- **PST** is the total PST for all goods and services included in this invoice. Goods and services to which PST applies are identified with a check mark in the PST column.
- **Interest** is the total amount due for overdue outstanding balances and is based on the Overdue Amount calculated in the section: "Account Activity Since Last Invoice." Interest is calculated in accordance with the Statutory Accident Benefits Schedule.
- **Auto Insurer Total** is the sum of all amounts in this section.

Make cheque payable to:	Family Care Clinic
Other Information:	

***Make cheque payable to***

Enter the name of the facility, clinic, or person to whom the cheque should be made payable.

***Other Information***

This space may be used to communicate any additional information that will help the insurer process the invoice.

***For Insurer Use***

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

This table is provided for insurers' review, approval, and payment processes and to assist with communication with accounting functions. The grand total is broken down to allow sub-ledgering of interest separately from medical payments.

