

Auto Insurance Standard Invoice (OCF-21)

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

****Claim Number:**

****Policy Number:**

Date of Accident:
(YYYYMMDD)

To be used for medical and rehabilitation goods and services that are payable by an automobile insurer. The User Manual for completion of the form and its versions may be found at www.hcaiinfo.ca.

Confidentiality: Collection, use and disclosure of this information are subject to all applicable privacy legislation.

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

Attach Version C - pages 2 and 3 for Minor Injury Guideline for accidents that occurred on or after September 1, 2010.

Attach Version A - page 2 where there is a previously approved treatment or assessment plan.

Version B - pages 2 and 3 must be used for all other goods and services and may be used for previously approved treatment plans and assessments, at the discretion of the provider.

Part 1 Applicant Information

Date Of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Telephone Number	Extension
Last Name			
First Name		*** Middle Name	
Address			
City	Province	Postal Code	

Part 2 Insurance Company Information

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: <input type="checkbox"/> Applicant OR	**Policy Holder Last Name	*Policy Holder First Name	

Part 3 Invoice Information

Invoice Number	First Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Invoice <input type="checkbox"/> Yes <input type="checkbox"/> No		
For previously approved goods and services, please complete the following:				
*Type of Plan or Minor Injury Guideline	*Plan Date (YYYYMMDD)	Plan Number	*Approved Amount	*Previously Billed
<input type="checkbox"/> Treatment and Assessment Plan (OCF-18) ♦				
<input type="checkbox"/> Minor Injury Guideline	Type: *			
♦ Attach Version A or B For all other Invoices, attach Version B * Attach Version C				

Part 4 Payee Information

If Service Address is same as Billing Address check here and **DO NOT COMPLETE Service Address**

Facility Name (if applicable)			HCAI Facility Registry Number		FSCO Licence Number (if applicable)	
Payee Last Name			Payee First Name		Payee Number (if applicable)	
Billing Address				Service Address (place where service is provided, but not patient address)		
City	Province	Postal Code		City	Province	Postal Code
Telephone Number		Extension		*Fax Number		
*Email Address						
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 act or practice. 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.						
Name of Provider or Authorized Signatory (please print)				Signature of Provider or Authorized Signatory		Date (YYYYMMDD)

OCF-21 - Version B - page 3

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

OTHER INSURANCE: I have made reasonable enquiries of the claimant 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 goods and services included in this invoice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

Other Insurance details are not required if they are the same as those on a pre-approved plan.

Other Insurance (for goods and services on this invoice)	Enter amounts that have or will be paid by "other" insurers, which will be deducted from this invoice total.			Enter amounts assigned to "other" insurers on prior invoices that were not paid. Amount will be added to this invoice total. Note: Auto Insurers may request EOB for amounts added to invoice total.		
	MOH	Insurer 1	Insurer 2	MOH	Insurer 1	Insurer 2
	Chiropractic:					
Physiotherapy:						
Massage Therapy:						
¹ Other Service Type:						
Total:						
¹ Please Specify Other Service Type:						

Account Activity since Last Invoice (if interest is being charged)		Sub-Total:	
		MOH:	
*Prior Balance:		Other Insurer 1+2:	
*Payment Received from Auto Insurer:		Tax (if applicable):	
² Overdue Amount:		²Interest:	
² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.		Auto Insurer Total:	

Make cheque payable to: _____

***Other Information:

Are there any attachments? Yes No If yes, how many? _____

Send any attachments directly to the insurer

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

OCF-21 - Version C - page 3

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the Minor Injury Guideline.
For all other goods and services attach Version A or B.

Reimbursable Fees Within the Minor Injury Guideline:								
First Date of Service			Description	†Code	Provider Reference			Cost
YYYY	MM	DD			Provider 1	Provider 2	Provider 3	
†Refer to the User Manual at www.hcaiinfo.ca for coding.				Minor Injury Guideline Fee Totals:				

Other Insurance (for goods and services on this invoice)	Enter amounts that have or will be paid by "other" insurers, which will be deducted from this invoice total.			Enter amounts assigned to "other" insurers on prior invoices that were not paid. Amount will be added to this invoice total. Note: Auto Insurers may request EOB for amounts added to invoice total.			
	MOH	Insurer 1	Insurer 2	MOH	Insurer 1	Insurer 2	
	Chiropractic:						
	Physiotherapy:						
	Massage Therapy:						
	¹ Other Service Type:						
Total:							
¹ Please Specify Other Service Type:							

Account Activity since Last Invoice (if interest is being charged)		Sub-Total:
Prior Balance:		MOH:
Payment Received from Auto Insurer:		Other Insurer 1+2:
² Overdue Amount:		Tax (if applicable):
² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.		² Interest:
		Auto Insurer Total:

Make cheque payable to: _____

***Other Information:

Are there any attachments? Yes No If yes, how many? _____

Send any attachments directly to the insurer

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