

ECHELON

GENERAL INSURANCE COMPANY

1550 Enterprise Road, Suite 310,
Mississauga, Ontario L4W 4P4

Auto Insurance Standard Invoice (OCF-21)

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

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

Attach Version C - pages 2 and 3 for Pre-approved Frameworks (PAFs). 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.

Please provide all information requested.

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

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 Pre-approved Framework	Plan Date (YYYYMMDD)	Plan Number	Approved Amount	Previously Billed
<input type="checkbox"/> Treatment Plan (OCF-18) ♦				
<input type="checkbox"/> Assessment Plan (OCF-22) ♦				
<input type="checkbox"/> PAF Type: ♦				

♦ Attach Version A or B
♦ Attach Version C
For all other invoices, attach Version B

Part 4 Payee Information

Facility Name (if applicable)		AISI Facility Number (if applicable)	
Payee Last Name		Payee First Name	Payee Number (if applicable)
Address			
City		Province	Postal Code
Telephone Number - -		Extension	Fax Number - -
Email Address			
<input 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)		Signature of Health Professional Social Worker 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 or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

OTHER 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 Yes No Not applicable

Other Insurer Name	Other Insurance Plan Or Policy Number
Name of Plan Member	Other Insurer's Identifier
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.

Conflict of Interest Definition

A person has a conflict of interest relating to an invoice if:

- i. The person or a related person or another person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person, of the goods or services, 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.

Other Insurance (for goods and services on this invoice)	Chiropractic:	MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice (if Interest is being charged)	Sub-Total:	
	Physiotherapy:					Prior Balance:	MOH:
	Massage Therapy:				Payment Received from Auto Insurer:	Other Insurer 1 + 2:	
	¹ Other Service Type:				² Overdue Amount:	GST (if applicable):	PST (if applicable):
	¹ Please Specify Other Service Type:					² Interest:	Auto Insurer Total:

²The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.

Make cheque payable to:	For insurer's use only	
Other Information:		
Reviewed By:		
Approved By:		
Payee Name:	Total	Interest
Payment Amount:	Grand Total	

