



Health Claims for Auto Insurance

OCF-21C

MANUAL FOR WEB USERS

July 2015

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Create an OCF-21C in HCAI

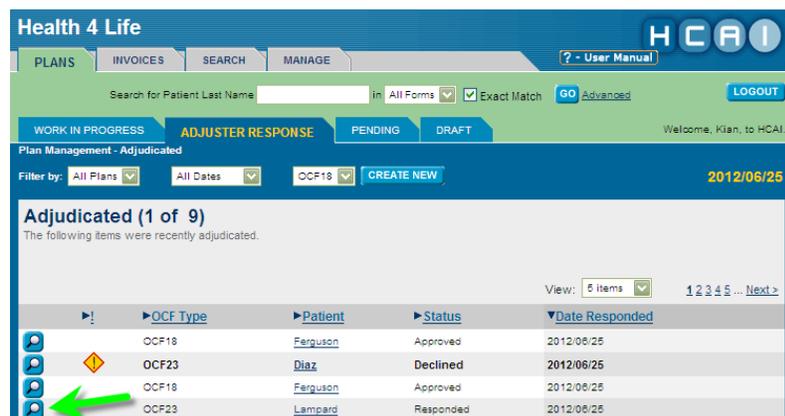
An OCF-21C is used when invoicing for goods and services delivered in the Minor Injury Guideline (for accidents on or after Sept 1, 2010) or the Pre-Approved Framework (for accidents prior to Sept 1, 2010).

In HCAI, there are two options for OCF-21C creation:

1. Create an Invoice from a Plan.
 - This option can be used once your Facility has submitted the associated OCF-23 via HCAI.
2. Create an Invoice from “scratch”.
 - This option is used when your Facility has not submitted an OCF-23 via HCAI.

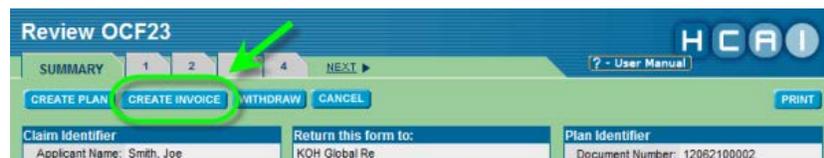
From a Plan Submitted via HCAI

Figure 1: Plans → Adjuster Response sub-tab



- Locate and open the submitted Plan by clicking on the magnifying glass icon (🔍) to the left of that Plan (see Figure 1).
- Once the Plan opens, click the **CREATE INVOICE** button (see Figure 2) and the OCF-21C is created.
- Many of the fields will be auto-populated from the submitted OCF-23.

Figure 2: Create Invoice from Plan



From Scratch

Figure 3: Invoices global tab



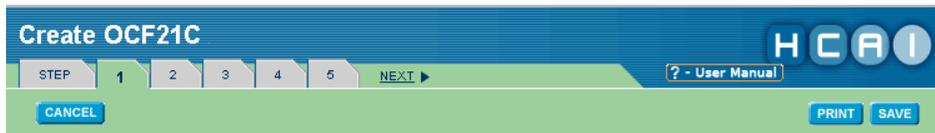
- Go to the Invoices tab and any sub-tab (see Figure 3).

- Select OCF-21C from the dropdown list and click the **CREATE NEW** button. A blank OCF-21C will open.

OCF-21C TABS

The OCF-21C in HCAI appears organized under five tabs.

Figure 4: OCF-21C tabs



Tab 1

[Claim Identifier](#)

[Invoice Identifier](#)

[Part 1 – Applicant \(Patient\) Information](#)

[Part 2 – Auto Insurer Information](#)

Tab 2

[Part 3 – Invoice details](#)

[Part 4 – Payee Information](#)

Tab 3

[Part 5 – Injury and Sequelae Codes](#)

[Part 6 – Goods and Services Rendered](#)

Tab 4

[Part 7 – Reimbursable Fees within the Minor Injury Guideline or Pre-approved Framework](#)

[Part 8 – Other Reimbursable Goods and Services Approved by the Insurer](#)

[Part 9 – Other Insurance \(for goods and services on this Invoice\)](#)

[Additional Information](#)

Tab 5

[Additional Comments \(and/or Attachments\)](#)

TAB 1

Claim Identifier

Figure 5: Claim Identifier

Create OCF21C

STEP 1 2 3 4 5 NEXT ►

? - User Manual

CANCEL PRINT SAVE

Claim Identifier

Applicant Name: Smith, John
Claim Number: 789456555
Policy Number: AP1234567
Date of Accident: 2012/03/01

Invoice Identifier

Document Number:
Invoice Number:
OCF Type: 21C
Date: 2012/07/06
Source: Web
OCF Effective Date: 2010/09/01
Archival Status: Not Archived

From Plan

- Data will be populated from the information on the submitted OCF-23. No edits are possible.

From Scratch

1. Enter Claim Number and/or Policy Number

- The Applicant must provide 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).
- The Claim Number and Policy Number may be the same.

2. Enter the accident date (forms will not be processed without an accident date)

- If the Applicant/Patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

Invoice Identifier

- This information will be populated when the Invoice is submitted. No action is required.

Part 1 – Applicant Information

From Plan

- Data will be populated from the information entered on the OCF-23. No edits are possible.

From Scratch

- If creating the OCF-21C from scratch, the Applicant or substitute decision-maker should provide this information to the Facility.
 - **Date of birth** of the Applicant/Patient.
 - **Gender** of the Applicant/Patient.

Part 2 – Auto Insurer Information

From Plan

- These fields are populated for you when creating the OCF-21C from a Plan.

From Scratch

- The Applicant or substitute decision-maker should provide this information to the Facility.

Independent adjusting companies and Adjusters

- Independent adjusting companies may be hired by Insurers to adjudicate Claims, but the HCAI application does not list independent adjusting companies.
- To direct OCFs appropriately, you should determine (typically by asking the Applicant/Patient or the independent Adjuster) the *name of the licensed Insurer* that insures the Applicant/Patient.

Policy Holder Details

- If the injured person seeking treatment is the Policy Holder, select “Yes” to the question “Is the Policy Holder the same as the Applicant?”
- If the injured person is not the Policy Holder, select “No” and enter the last name of the Policy Holder. The name of the Policy Holder can be obtained from the pink slip of the proof of insurance form.

TAB 2

Part 3 Invoice Details

- If your Facility uses an internal Invoice numbering system, you may enter it in the “Provider Invoice Number” field.
 - This number will appear in the HCAI worklist and will help you locate an Invoice after you have submitted it.
 - It is not a mandatory field and may be left blank.
- Click “Yes” for “First Invoice” if your Facility has not previously invoiced the Insurer for the associated Plan.
- Click “Yes” for “Last Invoice” if this is the last Invoice to be submitted for the associated Plan.

Previously Approved Goods and Services

From Plan

- When creating your Invoice from an OCF-23, the Plan’s Document Number will be auto-populated and will not be editable. It will also link to the associated Plan.

Figure 6: Invoice details

Part 3: Invoice Details

To aid in the decision-making process, please identify the plan for this claimant that is associated with this invoice and whether or not this is the first or last invoice under this plan.

Provider Invoice Number:

* First Invoice: No Yes

* Last Invoice: No Yes

Previously Approved Goods and Services

For previously approved goods and services, please complete the following:

Is this invoice for goods and services described on an OCF-23 in HCAI? No Yes

Please enter the HCAI Document Number of the Treatment Confirmation Form (OCF-23) to which this invoice corresponds. This is the eleven-digit "Document Number" in the Plan Identifier section in the top-right-hand corner of the OCF-23. If you wish to indicate that this submission is exempt from providing the OCF-23 number, answer "No" to the question above or type in "exempt".

* OCF-23 Document Number: 12062100002

From Scratch

- Click “Yes” if the goods and services being invoiced are included in the associated Plan and type the Plan’s Document Number.
 - If you do not have the Document Number, select “Yes” and type “exempt” (all lowercase) into the Document Number field. [FSCO’s HCAI Guideline](#) explains when it is appropriate to request an exemption.
- If your Invoice includes goods and services that are not described in an associated Plan, select “No”. This indicates you have selected an exemption from providing a Document Number.

Part 4 – Payee Information

Within the HCAI account's 'Facility Management' section, there is a question, 'Payee Field Editable on Invoices?'

- If "Yes" is selected, the "Make Cheque Payable To" field may be changed
- If "No" is selected, the field next to "Make Cheque Payable To" may not be edited.

Figure 7: Payee Information: "Yes" selected for "Lock Payable"

Part 4: Payee Information

Facility Name: Ontario Physio Care
HCAI Facility Registry Number: 100631
FSCO Licence Number: LicNo_100631
Make Cheque Payable To: Ontario Physio Care
Payee First Name:
Payee Last Name:
Payee Number:

Billing Address

Address 1: 200 Main St.
Address 2:
City: Toronto
Province: Ontario
Postal Code: M1M 1M1

Service Address

Same as billing address? No Yes

Phone: (416) 555-5555
Fax: (416) 111-1111
E-mail: Sue@email.ca

THE AUTHORIZED SUBMITTER CERTIFIES THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

THE AUTHORIZED SUBMITTER UNDERSTANDS 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.

THE AUTHORIZED SUBMITTER FURTHER UNDERSTANDS 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.** Note: Authorized signatures obtained during registration.

TAB 3

Part 5 – Injury and Sequelae Codes

From Plan

When you create an OCF-21C from a previously submitted Plan, the injuries on the Plan will be carried over to the Invoice.

- It is possible for you to change the injury codes used.
- Claimants treated in the Minor Injury Guideline (MIG) or in the Pre-approved Framework (PAF) generally have an injury or injuries consistent with the MIG or PAF Guideline.

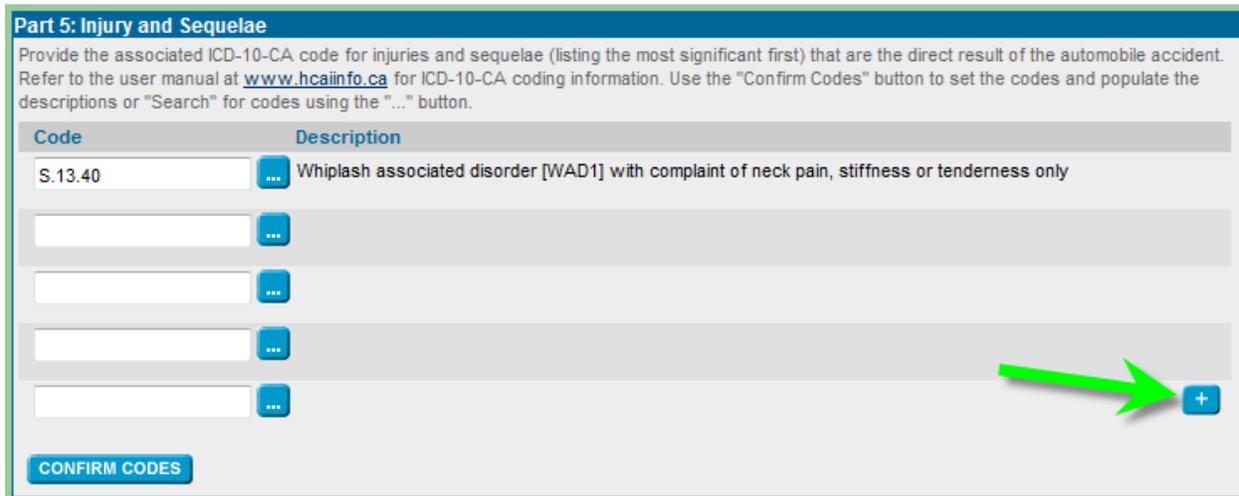
From Scratch

- List the injuries and sequelae that are a direct result of the automobile accident.
- Each code should be listed only once, regardless of how many Health Care Providers will be engaged in the treatment.
- The first line item should reflect the primary reason you are proposing services, with the most significant injury first.
- In a case where multiple injuries may be classified as the most significant, list the injury requiring the most services first.
- The use of ICD-10-CA codes is intended to convey problems and is not the equivalent of communicating a diagnosis.

Adding additional lines for injury/sequelae codes

To add lines for additional injuries, simply click the  button near the bottom of the Part 5 box (see Figure 8).

Figure 8: Injury and Sequelae



Code	Description
S.13.40	Whiplash associated disorder [WAD1] with complaint of neck pain, stiffness or tenderness only

Refer to [Appendix C](#), which is the partial pick list of injury/problem codes available at www.hcaiinfo.ca or contact your Health Professional Association.

Part 6 – Goods and Services Rendered

- Provide details of specific interventions that were delivered; e.g. exercise, education, stimulation (TENS, laser, US, etc.).
- Do **not** use MIG (or PAF) block billing codes in this section. See Part 7 for Block Fees

Figure 9: Goods and services lines

Date Services Rendered	Code	Description	Attr.	Provider Reference	Quantity/Measure
<input type="checkbox"/> 2012/06/01	H.XX.MR	Med/Rehab	<input type="checkbox"/>	Smith, Dave	1.00 PR
<input type="checkbox"/> 2012/06/01	1.SC.02	"Exercise, spinal vertebrae"	<input type="checkbox"/>	Smith, Dave	1.00 PR
<input type="checkbox"/> 2012/06/04	7.SP.60	"Education, promoting health and..."	<input type="checkbox"/>	Smith, Dave	1.00 PR
<input type="checkbox"/>			<input type="checkbox"/>		GD
<input type="checkbox"/>			<input type="checkbox"/>		GD

Date service rendered

- All dates on which the Claimant attended treatment should be listed.
- Dates should be formatted yyyy/mm/dd and may be cut and pasted if several line items were delivered on the same date
- The calendar utility may also be used.

Figure 10: Date Services Rendered

Code

- Enter the intervention by typing it directly into the field under "Code." Or use the code search utility by clicking the blue ellipses button (...) next to the "Code" field (see Figure 9).
- If using the search utility, select either "CCI" (Canadian Classification of Interventions) or "GAP".

Attribute

- These codes are used to indicate how the service was delivered or, for example, the number of views in an X-ray study.
- Attribute is not mandatory, and can be left blank.

Provider reference

- Use the dropdown list to select the Health Care Provider who delivered care on a given date.
- If more than one Health Care Provider delivered care, list only the one who was most responsible for each visit that is listed on the Invoice.

Insert one Provider for multiple line items

There is a shortcut for inserting one Provider name in multiple line items, as follows:

1. Complete all fields *except* for the “Provider Reference” fields.
2. Tick each box to the left of the each completed line item (see Figure 11).
3. Click the **APPLY PROVIDERS** button and select the name of the Provider from the dropdown list.

Figure 11: Apply one Provider to several line items

Date Services Rendered	Code	Description	Attr.	Provider Reference	Quantity/Measure
<input checked="" type="checkbox"/> 2012/06/13	1.UB.12	"Therapy, wrist joint"		Brand, Allison	1.00 HR
<input checked="" type="checkbox"/> 2012/06/14	1.TM.12	"Therapy, elbow joint"		Brand, Allison	1.00 HR
<input checked="" type="checkbox"/> 2012/06/19	1.BS.80	"Repair, nerve(s) of pelvis, hip..."		Brand, Allison	2.00 HR
<input type="checkbox"/>					GD
<input type="checkbox"/>					GD

DELETED APPLY PROVIDERS CONFIRM CODES

Add more Items: 5 Items GO

Use these buttons with the checkboxes on the left.

Quantity and unit measure

- Enter the quantity and unit measure of service that will be provided during a single treatment visit/session.
 - *Example*
 - 15 minutes = 0.25 HR
 - 1 procedure = 1 PR
 - 1 good (like a back support) = 1 GD
 - 10 km = 10 KM
 - 1 session = 1 SN
 - It is important to use the correct unit measure that corresponds to the service described.
 - Most treatment interventions should use the PR (procedure) or HR (hour) measure.
 - All “goods” must use the GD (goods) measure.
 - Disbursements, such as parking, may be conveyed using “Other” (AXXOT) goods and the GD measure must be used.
 - Mileage expense must be conveyed using the KM (kilometre) measure.
 - Do not use GD for documentation review or preparation.

TAB 4

Part 7 – Reimbursable Fees within the MIG or PAF

First Date of Service

- The first date that service was provided should be listed for each treatment. For block fees, this is the date the block of services was initiated.
- Dates should be formatted yyyy/mm/dd and may be cut and pasted if several line items were delivered on the same date.
- The calendar utility may also be used.

Figure 12: Date Services Rendered



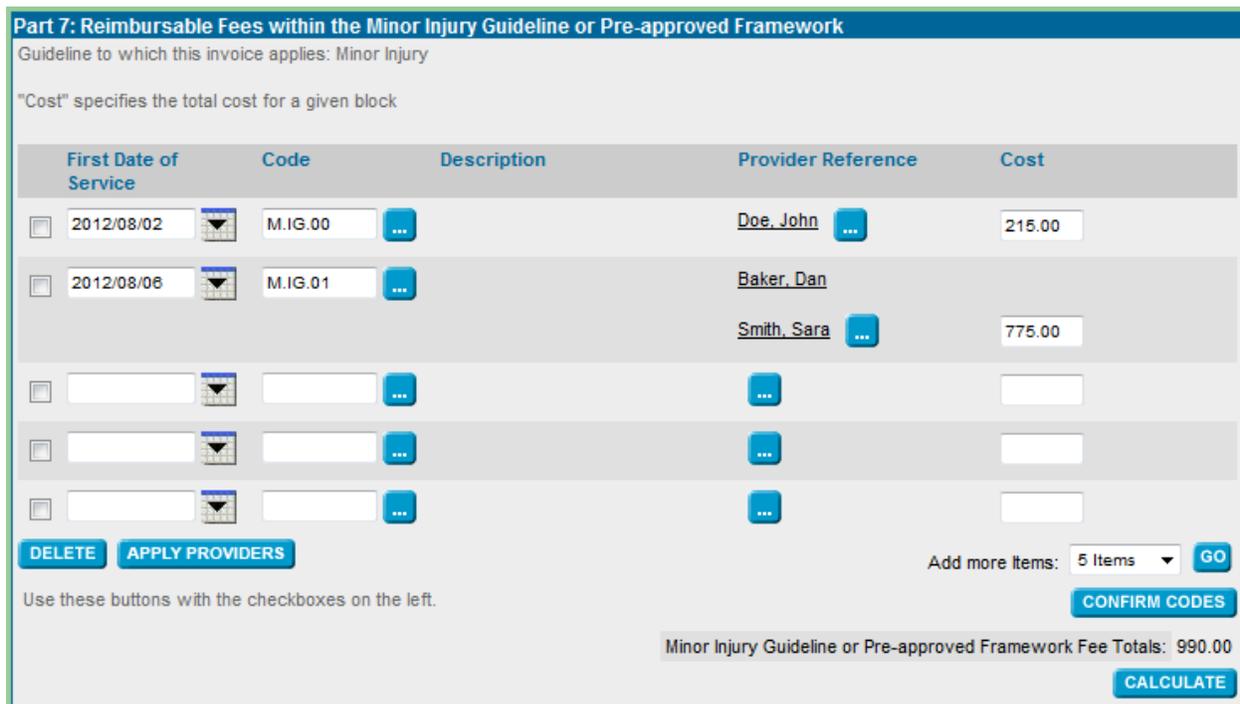
Date Services Rendered

2012/05/03

Code

- Enter the intervention by typing it directly into the field under “Code” or use the code search utility by clicking the blue ellipses button  next to the “Code” field.

Figure 13 – Part 7: Reimbursable Fees within the MIG or PAF



Part 7: Reimbursable Fees within the Minor Injury Guideline or Pre-approved Framework

Guideline to which this invoice applies: Minor Injury

"Cost" specifies the total cost for a given block

First Date of Service	Code	Description	Provider Reference	Cost
<input type="checkbox"/> 2012/08/02	M.IG.00		Doe, John	215.00
<input type="checkbox"/> 2012/08/06	M.IG.01		Baker, Dan Smith, Sara	775.00
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

DELETED APPLY PROVIDERS

Add more Items: 5 Items GO

CONFIRM CODES

Minor Injury Guideline or Pre-approved Framework Fee Totals: 990.00

CALCULATE

- If using the search utility, select the appropriate GAP code (MIG or PAF only).

Figure 14 – Search for MIG/PAF Codes

Search Goods and Services Codes

GAP codes are developed by The Insurance Bureau of Canada in conjunction with automobile insurers and health care providers to cover those items billed to automobile insurers by providers that are not covered by the Canadian Classification of Health Interventions (CCI). Items that fall outside of the realm of a medical procedure, intervention, or service are coded by using GAP codes. These include goods, supplies, assistive devices, mileage, travel time, independent medical examinations, Minor Injury Guideline blocks and Pre-approved Framework blocks. Only Minor Injury Guideline codes and Pre-approved Framework codes are approved codes for selection on Part 7 of an OCF-21C.

To begin the search, select the "Section" that is appropriate for your clinical situation. To narrow down the search results, select an "Intervention" and a "Group" prior to clicking the "Search" button.

Code Domain

GAP, MIG and PAF only

Section

Intervention

Group

CANCEL

- **Note:** CCI codes are not available under Part 7 of the OCF-21C. If PAF (date of accident on or before Sept 1, 2010), do not include Home/worksites/school visit and intervention here.
- The maximum fees payable by Insurers for pre-approved services are listed in the [MIG Guideline](#).
- To learn which services are pre-approved, read the MIG Guideline published by the Financial Services Commission of Ontario and available on the FSCO website (www.fSCO.gov.on.ca).

Provider reference

- Use the dropdown list to select the Health Care Provider(s) who delivered care for a given treatment block.
- At least one Provider must be listed for each treatment block. If more than one Health Care Provider delivered care, list up to three Providers who were most responsible for each treatment block listed on the Invoice.
- The Providers will be displayed in the order they were selected.

Figure 15: Select Providers

Select Providers

Please select one or more providers for this line item. At least one provider is required. Only the providers who have been associated with your facility will be available. A facility administrator can add a provider from the Facility Management tab.

Provider Name	Provider Profession
-----	-----
-----	-----
-----	-----

SUBMIT **CANCEL**

Insert Provider(s) for multiple line items

There is a shortcut for inserting one or more Provider name(s) in multiple line items, as follows:

4. Complete all fields *except* for the "Provider Reference" fields.
5. Tick each box to the left of each completed line item (see Figure 11).
6. Click the **APPLY PROVIDERS** button and select the name of the Provider(s) from the dropdown list.

Cost

- Enter the cost for each block of treatment.

Calculate

- Click **CALCULATE** to see the “Estimated MIG or PAF Sub-total.”

Part 8 – Other Reimbursable Goods and Services Approved by the Insurer – Only applies to accident dates prior to Sept 1, 2010.

From Plan

When the Invoice has been created from an OCF-23, it is possible to populate this section with the goods and services listed on Part 11 of the OCF-23. To do this:

1. Click **APPLY CODES FROM PLAN** (note: this button will not appear when creating an Invoice from an Archived Plan).

Figure 16: Apply codes from submitted Plan

Date Services Rendered	Code	Attr.	Provider Reference	Quantity/Measure	Cost	Tax
<input type="checkbox"/>		GD		<input type="checkbox"/>
<input type="checkbox"/>		GD		<input type="checkbox"/>
<input type="checkbox"/>		GD		<input type="checkbox"/>
<input type="checkbox"/>		GD		<input type="checkbox"/>
<input type="checkbox"/>		GD		<input type="checkbox"/>

Buttons: DELETE, APPLY PROVIDERS, **APPLY CODES FROM PLAN**, CONFIRM CODES, CALCULATE COSTS FROM RATES

GO, Add more Items: 5 Items

2. A screen will open that has a calendar to the right of each line of goods and services that were listed on the Plan.
 - Use the calendar function (see Figure 15) to select each date on which the specified service was delivered to the patient.
3. When all lines have been completed, click **APPLY CODES FROM PLAN** again.

Figure 17: Select dates on which service was delivered

Create OCF21C

Select each previously approved good and service by using the calendar to identify the date(s) of delivery. When all services and delivery dates have been identified, click **Apply Codes from Plan**. To return to the invoice without applying the date(s) of delivery, click **Cancel**.

APPLY CODES FROM PLAN

PWWOR Onsite work/home/school based review and intervention
Cost/Day on Plan: 415.90
Total Count:
Provider Reference: *East_Windsr*
Dates of Service:

AUXIM Mileage (Provider)
Cost/Day on Plan: 20.00
Total Count:
Provider Reference: *East_Windsr*
Dates of Service:

APPLY CODES FROM PLAN

4. All of the goods and services along with the Provider Reference, Quantity/Measure and Cost will populate the Invoice.
 - **Note:** It is possible to edit the lines of goods and services. It is also possible to add goods or services that did not appear on the Plan.
5. Apply the Default Hourly Rate – When the Providers listed on your Invoice were added to your Facility in HCAI, there was an option to assign a Default Hourly Rate. If the rate assigned is the correct rate to apply to your Invoice, click **CALCULATE COSTS FROM RATES**. (figure 16)
 - To manually enter or override the rate, enter the amount in the “Cost” field instead.
 - More information on how to calculate costs from rates and how to set a Provider’s Default Hourly Rate is explained in the [Provider Hourly Rates - Did You Know?](#) on HCAInfo.
6. If Tax is applicable to a line item, check the box in the “Tax” column.

Figure 18: Part 8 goods and services that were approved by Insurer

Part 8: Other Reimbursable Goods and Services Approved by the Insurer
 Other reimbursable goods and services must be within the PAF or Minor Injury Guidelines.
 If HST applies to a good or service, check the Proposed Tax checkbox on that line item.

Date Services Rendered	Code	Attr.	Provider Reference	Quantity/Measure	Cost	Tax
<input type="checkbox"/> 2012/07/09	A.XX.KM Mileage (Provider...)	<input type="checkbox"/>	GP LastName, GP F...	65.00 KM	32.50	<input checked="" type="checkbox"/>
<input type="checkbox"/> 2012/07/09	P.WW.OR Onsite work/homef...	<input type="checkbox"/>	Dianna Lueck	1.00 PR	416.00	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>

Buttons: DELETE, APPLY PROVIDERS, Add more Items, GO, APPLY CODES FROM PLAN, CONFIRM CODES, CALCULATE COSTS FROM RATES

From Scratch

Date service rendered

Use the calendar utility to select the date on which the service was delivered, or insert the date (yyyy/mm/dd).

Code

- The codes required to populate Part 8 are all CCI and GAP codes.

Attribute

- These codes are used to indicate how the service was delivered or, for example, the number of views in an X-ray study.
- Attribute is not mandatory, and can be left blank.

Provider Reference

- Use the dropdown list to select the Health Care Provider who delivered care.
 - If more than one Health Care Provider delivered care, list only the one who was most responsible for each visit that is listed on the Invoice.

Quantity/Measure

- Enter the quantity and unit measure of service that was provided during the Insurer approved intervention.

Cost

- Report the cost per service as described in the line.
 - *Example:* If the service was delivered for 0.5 HR, the “Cost” column should reflect the cost to deliver that service by the provider listed for 0.5 HR. Note: Do not insert the hourly rate in this column. You may also calculate costs using the Provider’s default hourly rate.
 - *Example:* 15 minutes of massage. 0.25 HR by a massage therapist = 25% of the RMT’s hourly fee. $0.25 \times \$53.66 = \13.41 . This amount should be entered in the field under the “Cost” column.
 - If Tax is applicable to a line item, check the appropriate *Tax* box(es).

To learn which services are pre-approved, read the PAF Guideline published by the Financial Services Commission of Ontario and available on the FSCO website (www.fSCO.gov.on.ca).

Part 9 – Other Insurance (for goods and services on this invoice)

1. If amounts are payable by another Insurer, enter the amounts within the ‘Other Insurance (for goods and services on this invoice) section. Do not use a negative (-) sign for these amounts. These amounts will be deducted from the amount owed by the Insurer.
2. For amounts previously identified for payment by another Insurer but subsequently ruled ineligible, select ‘Yes’ for the question, “Do you want to claim any amount not reimbursed by other insurance sources?” Enter the amounts for the corresponding Insurer in the section that appears.
 - a. When the category “Other” is used, specify the type of services covered (e.g. dental, psychological, optometric).
3. Click the **CALCULATE** button to see the total for each line.

Figure 19: Other insurance

Other Insurance (for goods and services on this invoice)

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).

Use the section below to indicate the amount you have received or will receive directly from the collateral source or applicant. Enter the amounts as positive values. These amounts will be subtracted from the sub-total to determine the amount owed by the automobile insurer.

	Chiropractic	Physiotherapy	Massage Therapy	**Other Services	Total
MOH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00
Insurer 1	<input type="text" value="250.00"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="50.00"/>	300.00
Insurer 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00

**Other Service Type Specified:

Do you want to claim any amount not reimbursed by other insurance sources? No Yes **CALCULATE**

Totalling

- *Pre-approved Sub-total* – Proposed Goods and Services Sub-total (calculated in **Tab 4**).
- *Other Goods and Services* – Calculates amounts from Part 8: Other Reimbursable Goods and Services Approved by the Insurer.
- *Minus MOH* – sum of all Ministry of Health and Long-Term Care amounts.
- *Minus Other Insurer (1 + 2)* – sum of all amounts received or payable to you from other Insurers.

The following amounts are not added to the calculation of the *Auto Insurer Total*

- *Prior Balance* - the “Auto Insurer Total” from your last Invoice.
- *Overdue Amount*
- *Payments Received from Auto Insurer* since your last Invoice to calculate Overdue Amount.

Interest amount is added to the total.

- *Interest* – owed to your HCF as a result of the Overdue Amount.

When all of the proposed goods and/or services have been entered and any required fields in the Totalling section have been completed, click **CALCULATE**.

HCAI calculates Tax (HST) and enters the amount into the *Auto Insurer Total*.

If you wish to manually enter a different tax amount for your invoiced goods/services:

- I. Click and uncheck the button underneath the Totalling box.
- II. Enter the new amount in the “Tax (if applicable)” field.

Click **CALCULATE** for the new “Auto Insurer Total

Note: Taxes are included in the MIG block billing fees. The OCF-21C only permits taxes to be selected for line items in Part 8.

Figure 20: Totalling

	Proposed	Calculated
Pre-approved Sub-total:	435.00	
Other Goods and Services:	75.00	
* Minus MOH:	(50.00)	
* Minus Other Insurer (1 + 2):	(200.00)	
Tax (if applicable):	5.00	9.75
Prior Balance:	0.00	
Payment Received from Auto Insurer:	0.00	
Overdue Amount:	0.00	
Interest:	15.00	
Auto Insurer Total:	275.00	

HCAI populates the proposed and calculated tax columns with the HST rate (13%). You may overwrite the Proposed Tax amount if you are charging a tax value that is different from HST.

CALCULATE

Recalculate proposed tax to reflect HST on selected taxable items

It is possible to request payment for amounts greater than or less than those proposed on a Plan, but the Insurer may request an explanation.

Additional Information

- In Tab 4, near the bottom of the HCAI page, there is space that permits comments if there is a need to provide the Insurer additional explanations/clarifications.
- Only 500 characters are allowed here. If more space is needed, use Tab 5.

Figure 21: Additional information

Make cheque payable to: Acme Rehab

Other Information:

CANCEL **PRINT** **SAVE** **SUBMIT**

TAB 5

Additional Comments & Attachments

Figure 22: Additional comments and attachments

Additional Comments

Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer. It is mandatory to indicate the number and types of documents/reports that are being sent.

Attachments being sent, if any.

Family physician report enclosed.

- HCAI permits Facilities to do the following:
 - Offer more information to Adjusters by using the space provided in Tab 5.
 - Advise Adjusters that additional documentation (attachments) is being sent which the Insurer requires to adjudicate the form.

How should attachments be sent?

- Attachments must be faxed/mailed directly to the Adjuster.
 - Attachments cannot be sent electronically via HCAI and should not be sent to HCAI.
- To indicate that an attachment is being sent to the Adjuster, check off “Attachments being sent, if any.”
 - If this box is ticked, the Facility must use the space below to describe the attachment being sent.