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	*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: ☐ Applicant OR	**Policy Holder Last Name	*Policy Holder First Name

Part 3 Invoice Information

Invoice Number	**First Invoice** ☐ Yes ☐ No	**Last Invoice** ☐ Yes ☐ 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
☐ Treatment and Assessment Plan (OCF-18) ♦						
☐ Minor Injury Guideline	Type:	♣				

♦ Attach Version A or B
♣ Attach Version C

For all other Invoices, attach Version B

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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		FSRA 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					

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you and persons acting for you, will collect business, personal and personal health information that is related to the applicant's claim for accident benefits arising out of the accident referenced in this invoice and that all such information will be collected directly from me or from any other person with my consent.

I ALSO UNDERSTAND that you and persons acting for you will collect information about this invoice prepared by me.

I ALSO UNDERSTAND that if I am the health service provider for the applicant that you, and persons acting for you, will collect information related to this claim that is provided by me on this invoice or any other auto insurance application form.

I ALSO UNDERSTAND that the information within this form will be collected and used only as reasonably necessary, with the applicant's consent for the purposes of:

- Investigating the claims of the applicant and processing the claims of the applicant as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to the applicant's claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with the applicant's claims;
- Identifying and analysing the nature and costs of goods and services that are provided to automobile insurance claimants by health care providers;
- Preventing, detecting and suppressing fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons or organizations, who may collect and use this information only as reasonably necessary to enable you or them to carry out the purposes described above:

Insurers; insurance adjusters, agents and brokers; employers; health care providers; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations; other insurance companies; the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.

I ALSO UNDERSTAND that you, and persons acting for you, may pool this information with information from other sources and may analyze this information for the limited purpose of preventing, detecting or suppressing fraud.

I CONSENT to you collecting, using and disclosing information relating to this claim form in the manner described above, which will be limited to information that is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with the insurance company representative or a legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

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 in connection with a person's entitled to a benefit 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 and/or FSRA rules 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 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.**

To obtain further information about privacy related issues please contact the Privacy Officer at the insurance company listed in Part 2.

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit https://www.ibc.ca/information-privacy-and-you

Name of Provider or Authorized Signatory (please print)	Signature of Provider or Authorized Signatory	Date (YYYYMMDD)

PRINT RESET SAVE

OCF-21 - Version A - page 2

This form may be used for billing goods and services that have been previously approved by the insurer through an OCF-18.
This form may not be used for Minor Injury Guideline (use Version C - pages 2 and 3) or for goods and services that have not been previously approved (use Version B - pages 2 and 3).

Effective July 1, 2026, auto insurers are the first payors for medical and rehabilitation benefits. This change does not apply to medication expenses, which should be submitted to supplementary health insurance plans first.

Injuries and Sequelae	
Description	**†Code**

Injury details are not required if they are the same as those on an approved plan.
† Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers				Regulated (College Registration Number)	Unregulated (If applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	**†Type**	**Last Name**	**First Name**				
A							
B							
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 for coding.

†G/S Ref	Month (yyyy-mm):																													Tax	Cost/ Day	Total Count	Total Cost
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				

† Refer to the previously approved plan for each good and service reference number (G/S Ref).
Enter the Provider Reference from the previously approved plan or the Provider table above at the intersection of the date of service and the G/S Ref indicating the provider who rendered or prescribed the service or good.

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:

PRINT **RESET** **SAVE**

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).

Injuries and Sequelae	
Description	†Code

Injury details are not required if they are the same as those on a previously approved plan.
†Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers				Regulated (College Registration Number)	Unregulated (If applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	†Type	Last Name	First Name				
A							
B							
C							
D							
E							
F							

Provider details are not required if they are the same as those on a previously approved plan.
† Refer to the User Manual at www.hcaiinfo.ca for coding.

Date of Service			Description	†Code	†Attribute	Provider Reference	Quantity	†Measure	Tax (✔)	Cost
YYYY	MM	DD								
† Refer to the User Manual at www.hcaiinfo.ca for coding.							Sub-Total			

Send any attachments directly to insurer

PRINT RESET SAVE

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).

Effective July 1, 2026, auto insurers are the first payors for medical and rehabilitation benefits. This change does not apply to medication expenses, which should be submitted to supplementary health insurance plans first.

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 (MOH) coverage for goods and services included in this invoice? ☐ Yes ☐ No ☐ 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:		**[2]Interest:**	
[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

PRINT **RESET** **SAVE**

OCF-21 - Version C - page 2

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.

Injuries and Sequelae	
Description	**†Code**

Injury details are not required if they are the same as those on the Treatment Confirmation Form (OCF-23)
†Refer to the User Manual at www.hcaiinfo.ca for coding.

Providers				Regulated (College Registration Number)	Unregulated (If applicable, or blank)	*Hourly Rate	For Insurer's Use
Ref	**†Type**	**Last Name**	**First Name**				
A							
B							
C							
D							
E							
F							

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

Goods and Services Rendered (Minor Injury Guideline 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						

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

PRINT RESET SAVE

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.

Effective July 1, 2026, auto insurers are the first payors for medical and rehabilitation benefits. This change does not apply to medication expenses, which should be submitted to supplementary health insurance plans first.

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

PRINT RESET SAVE