Return this form to:

Treatment and Assessment Plan (OCF-18)

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

****Claim Number:**	
****Policy Number:**	
Date of Accident: (YYYYMMDD)	

NOTE: A Treatment and Assessment Plan (OCF- 18) is not required to make the following claims:

- ambulance or other goods or services provided on an emergency basis not more than 5 business days after the accident
- drugs prescribed by a regulated health professional
- dental goods or services (submitted on the Standard Dental Claim Form)
- goods referenced in s.15(1)(d) to (f) and s.16(3)(h) to (j) with a cost of $250 or less per item
- goods and services referenced in s.15(1)(h) or 16(3)(l) if the insurer agrees the expense is essential for the treatment or rehabilitation of the insured person with a cost of $250 or less per item or service

If this is an impairment that comes within the Minor Injury Guideline applicable to the accident (for accidents that occurred on or after September 1, 2010) an OCF – 23 Treatment Confirmation Form is required instead of this form.

To the Applicant:
Please provide information for the completion of Parts 1 and 2 and 3. After your regulated health professional has reviewed your Treatment and Assessment Plan with you, sign Part 10 and initial Part 12.

Your regulated health professional will complete all other parts of the form.

Collection, use and disclosure of this information are subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

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**

To the Regulated Health Professional/Facility:
To the extent possible, this Treatment and Assessment Plan should include all goods and services contemplated by the regulated health professional referred to in Part 5.

A health practitioner (i.e., chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 4.

Complete Part 6 based on your most recent examination of the applicant named and return the form to the insurance company listed in Part 2. Please print clearly.

Consent: It is the responsibility of regulated health professionals to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Ontario Claims Form 5 (OCF – 5) *Permission to Disclose Health Information* may be used as a consent form.

Part 1 Applicant Information

To be provided by the applicant

Date Of Birth (YYYYMMDD)	Gender: ☐ Male ☐ Female	*Telephone Number Extension
Last Name		
First Name	***Middle Name	
Address		
City	Province	Postal Code

Part 2 Insurance Company Information

To be provided by the applicant

Insurance 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