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Applicant Name:	McLean, Kevin	OCF-18	Policy Number:	001013511806
Provider Name:	Dhaliwal, Manginder		Claim Number:	035325790-3
Provider Fax:			Date of Accident:	2022-08-31

Part 11 Health Care Providers

Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (If applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A	PT	Dhaliwal	Manginder	11856		

Part 12 Proposed Goods or Services Requiring Insurer Approval

To the extent possible, this Treatment and Assessment Plan should include **all goods and services (G/S)** contemplated by the Regulated Health Professional referred to in Part 5 for the period of this Treatment and Assessment Plan

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimated			Projected	
					Quantity	†Measure	Cost	Total Count	Total Cost
1	Physical rehabilitation	S.ZZ.PR		A	1.00	HR	99.75	26	2593.50
2	"Assessment (examination), total body"	2.ZZ.02		A	1.00	HR	215.00	1	215.00

Estimated duration of this Plan:	**12 Weeks**	**Sub-total:**	**27** **2808.50**
***How many visits have you already provided:**	**10 *visits**	**Minus MOH:**	**0.00**
		Minus Other Insurer 1 + 2:	**0.00**
		Tax (if applicable):	**0.00**
		Auto Insurer Total:	**2808.50**

Note : †Refer to the User Manual coding guidelines posted at https://www.hcalinfo.ca .

Attributes codes are used to further qualify the service codes and are described in the manual.

Payment by auto insurer is secondary to available collateral benefits.

Applicant or Substitute Decision Maker confirms consent to proposed goods and services: **Initials:**

*Please indicate any additional comments regarding proposed goods and services:

Are there any attachments? ☐ **Yes** ☒ **No**

If Yes, how many?____
Send any attachments directly to the insurer

Part 13 Signature of Insurer

☐ ***I waive the requirement of the Applicant's signature.

I have reviewed the Treatment and Assessment Plan and based upon the information provided, I:

☐ Approve this Treatment and Assessment Plan ☒ Partially approve ☐ Do not approve

The Statutory Accident Benefits Schedule states that the insurer shall, within 10 business days of receiving this Treatment and Assessment Plan, give the applicant a notice stating the goods and services contemplated by the Treatment and Assessment Plan for which the insurer will or will not pay.

Name of Adjuster (please print)	Signature of Adjuster	Date (YYYY-MM-DD)
Nurse, Alisha-Anne	As per A. Nurse KW	2023-04-20

To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 4 and the Regulated Health Professional indicated in Part 5.

Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Regulated Health Professional referred to in Part 5 will contact each of the health care providers listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment and Assessment Plan.