NOVA SCOTIA MEDICAL SERVICES INSURANCE

NOVA SCOTIA

Outside of Canada Emergency Services Claim Form

Before You Begin

If you have private travel insurance and have already submitted a claim to your insurer, please wait for their decision before completing and submitting this form, as submitting to both your insurer and the province at the same time may cause delays.

A portion of the cost of emergency inpatient physician and hospital services received outside Canada may be paid for residents who are eligible for coverage under the Nova Scotia Health Insurance Program while temporarily absent from the province. To qualify, the services must be the result of an acute and unexpected emergency that required immediate inpatient hospital treatment.

You may use this form to request reimbursement for services you have already paid for, or to request direct payment to an out of country hospital or physician for an unpaid invoice. If you have already paid for services, reimbursement may be issued directly to you as the applicant. If you have not paid an invoice, eligible payment may be issued directly to the out of country hospital, facility, or provider. Claims must be submitted within six months of the date of service or date of hospital discharge. Late submissions cannot be considered.

Payment is issued at prevailing Nova Scotia rates for insured inpatient physician services. Hospital reimbursements will be issued at the applicable rate. Any remaining balance is the responsibility of the applicant.

Required documents (please submit clear scanned copies):

- Detailed medical notes and documentation, including reason for admission, diagnosis, and treatment. If documents are not in English, an official translation may be required.
- Detailed receipts/invoices, and proof of payment (if applicable).
- Private insurance decision (if applicable)

Section A – Personal Information

Last Name	First Name	Middle Name

Date of Birth Day Month Year	NS Health Card Number

Daytime Phone Number	Email Address

Mailing Address	City/Town/Community	Province/State	Postal/Zip Code	Country

Civic Address (if different)	Civic Address City/Town/Community

Section B – Travel Details

Departure date: _____ Return date: _____ Reason for travel: _____

Country: _____ Currency of services billed: _____

Was your return delayed? ☐ No ☐ Yes If Yes: Please explain why: _____

Do you have coverage by any travel/health insurance? ☐ No ☐ Yes

If Yes: Provide the insurance company name and policy number: _____

Section C – Emergency Services

Did you receive treatment due to an emergency (accident or sudden attack of illness)? ☐ No ☐ Yes

Were you admitted into a hospital? ☐ No ☐ Yes

Nature of the illness/diagnosis: _____

Hospital/facility name: _____ Hospital/facility address (full address): _____

Physician name: _____ Physician address (full address): _____

Section D – Request for Payment (If the amounts are not in CAD, include the currency)

Physician bill: _____ Amount paid (include receipts): _____ Outstanding balance: _____

Hospital/facility bill: _____ Amount paid (include receipts): _____ Outstanding balance: _____

Who should receive the reimbursement? ☐ Applicant ☐ Out of country physician, hospital or facility

NOVA SCOTIA MEDICAL SERVICES INSURANCE

NOVA SCOTIA

Section E – Signature

- I certify that I am a resident of Nova Scotia and that the information provided on this form is complete, and accurate to the best of my knowledge.
- I understand and acknowledge that MSI will review and provide payment for eligible physician claims, and the Nova Scotia Department of Health and Wellness (DHW) will review and provide payment for eligible facility claims. MSI will direct facility claims on my behalf to the Department of Health and Wellness.
- I certify that I am not receiving reimbursement from any other insurer for this claim.
- I understand and acknowledge that any outstanding expenses not paid by MSI or DHW will be my responsibility.

Consent to Release Personal Heath Information and Communicate with a hospital/facility or provider to administer this claim.

- In accordance with the Nova Scotia *Personal Health Information Act* (PHIA), and the *Personal Information International Disclosure Protection Act* (PIIDPA), I consent to the collection, use, and disclosure of my personal health information and personal information as necessary for the administration of this claim. I understand this may include sharing information with the Department of Health and Wellness (DHW) and with physicians and/or healthcare facilities outside of Canada who are requesting payment.
- I also consent to MSI and DHW contacting me regarding my claim at the address, email address and telephone number that I have provided.
- I understand that I may revoke my consent at any time, but this may affect the payment of my claim.

Consent valid from _____ to (we recommend at least 6 months).

I acknowledge and agree that by signing below, I accept the terms of this reimbursement. I understand that reimbursement cannot be issued to out of country physicians without the patient's (or substitute decision maker's) signed consent.

Applicant _____ Date _____

Signature is required to complete this form.

Substitute Decision Maker (Complete this section if you are applying on behalf of someone who is unable to sign for themselves)

_____ _____ Date _____

Legal name | Signature is required to complete this form.

Submit your form

Online:	By mail:	By fax:
https://novascotia.ca/dhw-ms-01	MSI Pay Patient PO Box 500 Halifax NS B3J 2S1	902-490-2275

For questions, please call 902-496-7011 or 1-866-553-0585 (toll-free in Canada)

The personal health information submitted above is protected by the *Personal Health Information Act* and is only collected, used, retained, and disclosed to process your request unless otherwise authorized by the legislation or with your express consent. This information is collected under the authority of the *Health Services and Insurance Act*, or the *Fair Drug Pricing Act* to administer Nova Scotia's health insurance and drug programs.