msi
NOVA SCOTIA MEDICAL SERVICES INSURANCE

NOVA SCOTIA

Within Canada Services Claim Form

Before You Begin

Under the portability provision of the Canada Health Act, the Nova Scotia Medical Services Insurance Program provides coverage for insured physician and hospital services received in other provinces of Canada. In Quebec, you may be asked to pay and submit a claim to Nova Scotia for coverage for some services. https://www.novascotia.ca/healthcare-coverage-within-canada-health-card. If you present a valid Nova Scotia health card to an out of province health care provider for insured services, there is normally no charge to you. If you are asked to pay for an insured service received in Nova Scotia or elsewhere in Canada, you may be eligible for reimbursement up to the applicable rate by submitting this form.

You may use this form to request reimbursement for eligible inpatient hospital services, outpatient facility services, and physician services that you have already paid for. Physician services are reimbursed at the rate allowed for the service in the province or territory where the service was provided. Inpatient and outpatient facility services are reimbursed at the applicable reciprocal billing rate. Eligible reimbursement will be issued directly to you as the applicant.

Please note that services provided in private facilities may not be eligible for reimbursement without pre-approval by MSI. Some services are insured only if they are received within Nova Scotia (like Pharmacare and Dental programs). Visit Healthcare coverage within Canada: https://www.novascotia.ca/healthcare-coverage-within-canada-health-card to learn more.

Claims must be submitted within twelve months of the date of service or date of hospital discharge. Late submissions cannot be considered.

Required documents (please submit clear scanned copies):

- Detailed medical notes and documentation, including reason for visit, diagnosis, and treatment or services received.
- Detailed receipts/invoices, and proof of payment.

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 – Health Care Services

Province or territory where you received service(s): ____

Which of the following services did you receive? (Select all that apply.) Inpatient Outpatient Physician

Description of services received: ____

Hospital name (or facility number): ________________________ Hospital address: __________________________

Outpatient facility name (or facility number): _________________ Outpatient facility address: _________________

Physician name: ____________________________ Physician address: ____________________________________

Section C – Request for Payment

Inpatient bill: _______________ Amount paid (include receipts): ______________

Outpatient bill: ______________ Amount paid (include receipts): ______________

Physician bill: _______________ Amount paid (include receipts): ______________

Section D – 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 hospital and/or facility claims. MSI will direct facility claims on my behalf to the Department of Health and Wellness.
- 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), 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 Nova Scotia 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.

I acknowledge and agree that by signing below, I accept the terms of this reimbursement, and any outstanding amounts would be my responsibility.

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-03	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.