PHYSICIAN'S BULLETIN
July 17, 2026: Vol. LXXI, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News
MSI Online
HPV Vaccine
ADCP1
CFP1

Fees

New Fees
2 03.08B

Fee Updates
4 03.08 SP=GENP
5 03.09K/03.09L
8 C1001

Preamble Updates
8 GENP Consultation
8 UDS1
8 TI=GPEW
9 03.04J

Reminders/Updates
9 ME=CARE

In Every Issue

12 Updated Files
12 Useful Links
12 Contact Information

MSI News

MSI Online Services Now Available to Nova Scotia Residents

Nova Scotia has launched **MSI Online**, a new web-based portal designed to make it easier for residents to manage their information with MSI.
Residents can now conveniently update their information, renew their health card, register for programs, and submit inquiries and forms electronically.

MSI Online is available to eligible residents aged 19 and older who hold a Nova Scotia health card. The service can be accessed through any internet-enabled device using a standard web browser (such as Safari, Chrome, or Microsoft Edge), or through the **YourHealthNS** mobile app.

Through MSI Online, users can:

- Register an email address to receive convenient electronic notifications, including health card renewal reminders
- Request a replacement Nova Scotia health card
- Update address and contact information
- Register for or renew coverage under the Nova Scotia Seniors' Pharmacare Program
- Update organ and tissue donation preferences
- Opt in to participate in medical research opportunities
- Submit inquiries and forms electronically for processing
- Contact MSI directly

Physician offices are encouraged to inform residents of this option, particularly when individuals present with an expired Health Card. Residents are encouraged to take advantage of this new service and may benefit from easier access to MSI services.

HPV VACCINE (13.59L RO=HPV9)

Effective June 15, 2026, eligibility has been expanded to include individuals less than 21 years of age who have missed or refused the HPV vaccine as part of the school-based program.
Nova Scotia Vaccine and Immunoglobulin Eligibility Policy

ADCP1 – Advance Care Planning Discussion Billing

As announced in the June 26, 2026 Physician's Bulletin, Interim Health Service Code (HSC) ADCP1 was inadvertently terminated effective May 31, 2026. This is now resolved and any rejected or held claims back to May 31 can now be submitted.

CFP1 – monthly meeting update

As outlined in the billing guidelines for the monthly CFP1 fee, the Health Service Code (HSC) is claimable only for months in which the family physician actively participates in at least one structured team meeting per month.

As a reminder, these meetings must be patient-centred and focused on collaborative care planning and the delivery of optimal patient care. Meetings held to discuss operational, facility, or staffing matters do not meet the requirements for CFP1 billing.

It is recognized that, on occasion, a physician may complete all preparation and collaborative activities leading up to a scheduled meeting but be unable to attend due to unforeseen circumstances. In these situations, a one-time annual exception to the monthly meeting attendance requirement may be granted.

Any unplanned absence must be appropriately documented. This exception is intended only for circumstances in which the physician has completed the preparatory work associated with the meeting but is unexpectedly called away and unable to attend.

While revisions to the HSC billing process are planned for a future update, in the interim, please include a note in the CFP1 claim indicating that no monthly meeting occurred during that month and ensure that supporting documentation is maintained to support the unplanned absence from the meeting.

NEW INTERIM FEES

Effective July 17, 2026 the following health service code is available for billing:

Category	Code	Description	Base Units
CONS	03.08B	**Focused Assessment – Family Physician** RF=REFD **Description** A Focused Assessment is a face to face, in-person visit rendered to a patient by a family physician: a) who has submitted a signed ME=CARE declaration to Medavie, is approved, and is providing care to a patient who is not on their patient panel OR b) is providing women's sexual and reproductive health services, including peri-menopause care, who is qualified to furnish advice or a service because of additional training or expertise in an area of medicine recognized by their peers, but who does not hold a CAC and therefore may not claim a consultation (HSC 03.08).	17 MSU +MU

BACK TO CONTENTS

Category	Code	Description	Base Units

Documentation of the physical examination must describe the pertinent positive and negative findings of the physical examination. It is not adequate to indicate 'physical exam is normal' without indicating what has been examined

The assessment of the patient must include: a history and physical examination appropriate for the presenting problem, and a review of relevant diagnostic imaging and/or laboratory results.

This service requires a written or documented verbal referral from a referring provider with an MSI number and a brief written report that includes the findings, opinion and recommendations to the referring provider for future ongoing care.

May be claimed up to four times per patient per physician per new medical condition per year. If the patient is seen again by the same physician for the same medical condition more than four times in one year, only a limited office visit may be claimed.

Billing Guidelines

- If only one MU (base rate) is claimed, start and stop times are not required.
- 80% of the total time must be spent in-person, face to face, with both the physician and patient present. There must be a minimum of 24 minutes of direct contact with the patient to claim the second multiple.
- When claiming an additional MU, start and stop times that captures the time spent with the patient must be recorded in the patient's health record and in text field of the claim.
- A Focused Assessment may be claimed to a maximum total of 60 minutes per patient per day.
- May be claimed up to four times per patient per physician per new medical condition per year.
- Physicians must have submitted a ME=CARE declaration letter before billing a Focused Assessment service
  OR
- Use the modifier RO=WSRH to indicate that this is for women's reproductive and sexual health services, including peri-menopause care
- Not available for Virtual Care.

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP with ME=CARE
OR
SP=GENP with RO=WSRH

Location:
LO=OFFC

Multiples:

Multiple	MSU	Total Time (Min)	Minimum Direct Patient Contact (Min)
1	17	15	N/A
2	17 + 13	30	24
3	17 + 13 + 13	45	36
4	17 + 13 + 13 + 13	60	48

BACK TO CONTENTS

FEE UPDATES

Effective July 17, 2026 the following health service code has been updated:

Category	Code	Description	
CONS	03.08	**Family Physician Consultation** **Description** A comprehensive consultation may only be claimed by family physicians (GENP) who hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold. All Preamble rules pertaining to consultations and comprehensive visits must be followed. Prolonged consultations are paid in 15-minute time blocks or portion thereof, 80% of the total time must be in direct physician to patient contact. Prolonged consultations are not to be confused with active treatment associated with detention. **Billing Guidelines** • When claiming an additional MU, start and stop times that captures the time spent with the patient must be documented in the health record and on the text field of the claim. • 80% of the total time must be spent in-person, face to face, with both the physician and patient present. There must be a minimum of 24 minutes of direct contact with the patient to claim an additional multiple. • Each consultation can be billed up to a maximum of 60 minutes (60MSU) per day. This would include a base fee plus up to 2 additional multiples of 15 minutes each. • Multiples/prolonged not applicable for virtual care, except when the service is performed via the provincial telehealth network using ME=TELE (see July 2016 bulletin). • New providers must submit evidence of their CAC to DNS to be added to the list of providers who may claim 03.08. **Multiples** 15 MSU per 15 minutes to a maximum of 2 multiples (60 minutes) per day **Specialty Restriction:** SP=GENP with Certificate of Added Competence (CAC) (Addiction Medicine, Care of the Elderly, Emergency Medicine, Enhanced Surgical Skills, Family Practice Anesthesia, Obstetric Surgical Skills, Palliative Care, Sports and Exercise Medicine) **Location:** LO=OFFC **Multiples:**	30 MSU +MU

Multiple	MSU	Total Time (Min)	Minimum Direct Patient Contact (Min)
1 (no additional multiples)	30	< 30	N/A
2	30 + 15	45	36
3	30 +15 + 15	60	48

BACK TO CONTENTS

It is important to be aware that if you work at a comprehensive family practice (ME=CARE eligible), a new fee code has been established to allow referred patients who are not a part of your practice panel to be billed at the enhanced rate for the first 15 minutes with an option for prolonged visits for more complex cases. Patients referred to ME=CARE physicians for focused assessments should use the Focused Assessment code. The ME=CARE prolonged 03.03 code should be used for services to those patients as indicated on the ME=CARE declaration.

Effective **July 17, 2026** the following health service code has been updated:

Category	Code	Description	
CONS	03.09K 03.09L	**Consultant Physician - providing synchronous advice** **Referring Provider - requesting advice**	25 MSU + MU 13 MSU + MU

Description

This health service code may be billed for synchronous verbal communication between the consultant physician and the referring provider regarding the assessment and management of the patient but without the consultant physician examining the patient.

It must be in real-time and includes face to face conversations, telephone calls, or secure video calls using a Nova Scotia Health approved platform.

The referring provider, after evaluation of the patient, shall formally request an opinion from a physician qualified to furnish advice.

The referring health care provider may be a family physician, specialist, nurse practitioner, midwife, optometrist, dentist, or other MSI referring provider seeking an expert opinion from the consulting physician due to the complexity and severity of the case.

The consultant physician may be a specialist registered with the College of Physicians and Surgeons in Nova Scotia, a family physician who has a certificate of added competence or a family physician authorized to use HSC 03.08 Consultation GENP.

The referring provider service includes the following elements:

- A formal request for an opinion is communicated to the consultant.
- A review of the patient's relevant history, relevant family history and relevant history of present complaint, any laboratory data, PACS images, medical records or other data and a review of the relevant physical findings are communicated to the consultant.

The consultant physician service includes the following elements:

- Providing an opinion and advice to the referring provider.
- A written report outlining the advice to the referring provider regarding medical management of the patient.

Documentation Requirements

Both the consultant physician and the referring health care provider shall document in their respective charts or EMRs:

1. The patient demographic information
2. The date of service and the start and stop times if multiples (MU) are billed

BACK TO CONTENTS

3. The clinical concern outlined by the referring provider including the relevant history, physical findings, medications, laboratory and diagnostic imaging results
4. The advice provided by the consultant
5. The name and/or provider number of the colleague providing or receiving advice

Billing Guidelines
The service is not billable when the purpose of the communication is to co-ordinate clerical or administrative aspects of a patient's care including but not limited to: arranging transfer, a hospital bed, a consultation, laboratory or diagnostic tests, etc. or relaying the results of investigations.

This service is not billable for synchronous conversations of less than 5 minutes of two-way medical discussion.

The service is billable only when the communication is rendered personally by the physician providing the service and it is not billable if the service is delegated to another health professional such as:

- Nurse practitioner (may be in the role of referring health care provider only)
- Resident in training
- Clinical fellow
- Medical student

The referring health care provider's billing number must be noted on the MSI claim from the consultant. This is not required for the referring health care physician's claim unless multiples are being claimed.

The consultant physician:

- The consultant physician's code is not payable in addition to any other service for the same patient on the same day.
- It is not payable if the patient is seen for an in-person consultation for the same issue within the subsequent 7 days after the scheduled discussion date.

The referring provider:

- The referring health care provider may bill their code when the communication with the consultant occurs on the same day as a patient visit or other service.

Multiples
Multiples are available for prolonged synchronous advice with select consultants only:

- General Internal Medicine,
- Neurology,
- Physical Medicine
- Paediatrics
- Obstetrics and Gynecology
- Psychiatry
- Palliative Medicine
- Endocrinology
- Geriatric Medicine
- Infectious Disease
- Respirology

BACK TO CONTENTS

Category	Code	Description

- Rheumatology
- Family Medicine with CAC or authorization to use HSC 03.08 Consultation GENP.

03.09K

Multiple	MSU	Total Time (Min)	Minimum Direct two way Medical Discussion (Min)
1	25	< 30	<24
2	25 + 17.5	45	36

03.09L

Multiple	MSU	Total Time (Min)	Minimum Direct two way Medical Discussion (Min)
1	13	< 30	24
2	13 + 13	45	36

All referring providers must include the consultant's billing number on their claim when claiming multiples.

If the discussion exceeds 30 minutes, an additional multiple may be claimed to a maximum total time of 45 minutes, 80% of the time must be spent in two-way medical discussion. Where MU are claimed, start/stop times must be recorded in the patient's health record and in the text of the claim.

03.09K 17.5 MSU per 15 mins
03.09L 13 MSU per 15 mins

Specialty Restriction:
No restriction without multiples

For Consultant multiples only:
SP=IMND, SP=NEUR, SP=PHMD, SP=PEDI, SP=OBGY, SP=PSYC, SP=ENME, SP=GEMD, SP=INDI, SP=RSMD, SP=RHEU, SP=GENP with CAC or authorization to use HSC 03.08 Consultation.

For referring providers:
Multiples are only paid when the referral is to one of the above consultants

C1001 – COMMUNITY ON CALL FOR CEC PHYSICIANS

Physicians are advised that **Eastern Memorial** has been added to the current facilities eligible for C1001 • Annapolis Community Health Centre • South Cumberland Community Centre • All Saint's Hospital • North Cumberland Memorial • Twin Oaks Memorial • Musquodoboit Valley Memorial • Baddeck: Victoria County Memorial • Cheticamp: Sacred Heart Community Health Centre • Guysborough: Guysborough Memorial • Neils Harbour: Buchanan Memorial • Tatamagouche: Lillian Fraser Memorial • Eastern Shore Memorial • Eastern Memorial.

BACK TO CONTENTS

PREAMBLE UPDATES

Please see new preamble effective July 17, 2026

New Definition
Family Physician (GENP) Comprehensive Consultation (03.08): When a patient is referred to a family physician (GENP), a comprehensive consultation may only be claimed by family physicians (GENP) who hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold. All Preamble rules pertaining to consultations and comprehensive visits must be followed. (5.1.225)

Effective July 17, 2026 preamble 5.1.266 has been updated:

Current Definition	New Definition
Urine Drug Screen Tray Fee (UDS1) (5.1.266) When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. (5.1.267) The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1 and OAT2. (5.1.268) Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. (5.1.269) Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. (5.1.270)	**Urine Drug Screen Tray Fee (UDS1) (5.1.266)** When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. (5.1.267) The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1, OAT2 **and 03.08 (SP=GENP).** (5.1.268) Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. (5.1.269) Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. (5.1.270)

Effective July 17, 2026, the eligible time for GP Enhanced Hours Modifier (5.1.188) has been updated:

Current Definition

5.1.230
TI=GPEW

Time Period	Time
Monday to Friday	6:00am-8:00am
Monday to Friday	5:00pm-10:00pm
Saturday and Sunday	9:00am-10:00pm
Recognized Holidays	9:00am-10:00pm

New Definition

5.1.230
TI=GPEW

Time Period	Time
Monday to Friday	6:00am-8:00am
Monday to Friday	5:00pm-10:00pm
Saturday and Sunday	**6:00am**-10:00pm
Recognized Holidays	**6:00am**-10:00pm

Effective July 17, 2026 the following Preamble has been updated:

Current Definition	New Definition
Comprehensive Evaluation of Suspected Autism Spectrum Disorder (HSC 03.04J) *(5.2.160)* This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported	Comprehensive Evaluation of Suspected Autism Spectrum Disorder (HSC 03.04J) *(5.2.160)* This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when

BACK TO CONTENTS

Current Definition	New Definition
only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. Time to generate a report and recommendations is considered to be included in the service. Start and stop times must be recorded in the health record. Reportable no more than once per patient per 12-month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*	the physician's time has been dedicated to this service encounter and no other concurrent clinical work**. If two visits are planned to complete the required elements, only the final visit may be reported as the health service code 03.04J. The first visit is included with the final 03.04J billing.** **If the service occurs over 2 visits, at least one of the visits must be in-person and the visit must occur within 2 weeks of the first. The medical record must clearly indicate when the visit is virtual. If exceptional circumstances that are beyond the physician's control occur, documentation must clearly indicate the reason for the second visit being delayed.** Time to generate a report and recommendations is included in the service**. Physicians must ensure all elements and dates of the 03.04J are documented in a single form, which should be within the patient's chart on the final service date of the 03.04J billing.** Start and stop times must be recorded in the health record. Reportable no more than once per patient per 12-month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*

Billing Matters Billing Reminders, Updates, New Explanatory Codes

FAMILY PHYSICIAN ENHANCED OFFICE VISIT FEES (ME=CARE)

On April 7, 2026, the Department of Health and Wellness (DHW) initiated a review of eligibility for enhanced office visit fees applicable to family physicians responsible for delivering comprehensive and continuous patient care. These enhanced fees are intended to distinguish longitudinal, full-scope care from episodic care typically provided in walk-in settings.

Eligibility for enhanced fees is restricted to family physicians who formally declare to providing comprehensive and continuous care.

Eligibility Requirements and Declaration

To maintain or obtain eligibility, physicians were required to submit a signed declaration confirming that they meet all of the following criteria:

- The physician is licensed to practice as a Family Physician in the Province of Nova Scotia.
- The physician delivers comprehensive, full-scope family medicine services to a defined panel of attached patients, including:
  - Maintaining a patient panel whose members recognize the physician as their primary "family doctor" and routinely schedule appointments accordingly;
  - Establishing and sustaining an ongoing therapeutic relationship as the primary care provider;
  - Ensuring continuity of care for patients across time and clinical needs.
- The physician maintains a complete and current primary healthcare record (medical chart) for each attached patient within the clinic where the patient is rostered.

BACK TO CONTENTS

- Where appropriate, the physician ensures access to qualified colleagues within their practice to support continuity of care during periods of absence.

All physicians intending to bill, or currently billing, enhanced office visit fees (ME=CARE) were required to submit an updated ME=CARE declaration to remain eligible.

Review Outcome and Billing Guidance
The eligibility review was completed, and physician records were updated effective July 20, 2026.
Physicians practicing across multiple clinics and/or payment models are reminded that ME=CARE fees may only be billed within clinical settings where the above eligibility criteria are fully satisfied.
Physicians who believe their eligibility for enhanced office visit fees (ME=CARE) has been incorrectly revoked may submit a new declaration using the form available at the following link:

Declaration Form:
https://www.novascotia.ca/family-physician-mecare-declaration

Exception: Longitudinal Family Medicine (LFM) Physicians
Physicians practicing under a Longitudinal Family Medicine (LFM) contract or LFM-aligned contract, including Dalhousie Family Medicine (DFM) physicians, are exempt from submitting a ME=CARE declaration. This exemption is based on the contractual requirement inherent to the LFM funding model, which already obligates the provision of comprehensive and continuous care to an attached patient panel.

FEE FOR SERVICE ROSTERING GRANT

Physicians are advised that the Fee for Service Rostering Grant has been issued. Please reach out to PhysicianAgreement@novascotia.ca if you have questions related to the grant.

PHYSICIAN'S MANUAL

Applicable updates in the Physician's Bulletin's will be reflected in the Physician's Manual within 3 weeks; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

INTERIM FEE REFERENCE GUIDE

Physicians are reminded of the Interim Fee Reference Guide (PDF) available on the MSI website, which provides a comprehensive list of all current interim fees.

BACK TO CONTENTS

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD107	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS IS AN ADD ON FEE THAT MAY ONLY BE CLAIMED WITH 03.08 SP=GENP, 03.08B OR HSCS ASSOCIATED WITH OAT PROVISION
GN151	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS HSC MAY ONLY BE CLAIMED BY FAMILY PHYSICIANS (GENP) WHO HOLD AND MAINTAIN A CERTIFICATE OF ADDED COMPETENCE (CAC) AWARDED BY THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC)
GN152	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS HSC HAS ALREADY BEEN CLAIMED 4 TIMES IN THE PREVIOUS 12 MONTHS FOR THIS DIAGNOSIS. PLEASE DELETE AND SUBMIT A LIMITED OFFICE VISIT INSTEAD.
GN153	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT WITH TEXT INDICATING THE CONSULTANT PROVIDER NUMBER
GN154	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.09K MAY NOT BE CLAIMED WITH ANY OTHER SERVICE ON THE SAME DAY
GN155	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.09K HAS ALREADY CLAIMED ON THIS DATE FOR THIS PATIENT. NO OTHER SERVICE MAY BE CLAIMED ON THIS DATE FOR THIS PATIENT.
GN156	SERVICE ENCOUNTER HAS BEEN REFUSED. YOUR SPECIALTY IS NOT ELIGIBLE TO CLAIM THIS HSC WITH MULTIPLES
GN157	SERVICE ENCOUNTER HAS BEEN REFUSED BECAUSE 03.09K HAS BEEN CLAIMED FOR THIS PATIENT IN THE PREVIOUS 7 DAYS
GN158	SERVICE ENCOUNTER HAS BEEN REFUSED. SERVICE PROVIDER MUST HAVE SUBMITTED A SIGNED ME=CARE DECLARATION LETTER OR BE PROVIDING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH SERVICES TO CLAIM THIS HSC
VT183	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS CODE MAY ONLY BE CLAIMED BY PAEDIATRICIANS TRAINED IN THE ADMINISTRATION OF THE AUTISM DIAGNOSTIC INTERVIEW AND APPROVED BY PPAS.
VT184	SERVICE ENCOUNTER HAS BEEN REFUSED. A COMPREHENSIVE CONSULT (03.08) MUST HAVE PREVIOUSLY BEEN BILLED FOR THE SAME PATIENT WITHIN THE PREVIOUS 12 MONTHS TO CLAIM THIS CODE
VT185	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.04L HAS ALREADY BEEN CLAIMED FOR THIS PATIENT

BACK TO CONTENTS

In every issue Helpful links, contact information, events and news, updated files

UPDATED FILES

Updated files reflecting changes are available for download on July 17, 2026. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT)

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
Toll-Free: 1-800-387-6665
(In Nova Scotia)
TTY/TDD: 1-800-670-8888

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

In partnership with

BACK TO CONTENTS