NOVA SCOTIA MEDICAL SERVICES INSURANCE

NOVA SCOTIA

MSI Physician Application

Physician Information

Last Name	First Name & Initials	Date of Birth Day Month Year

Country of Birth	If Canada, which province	Sex Male ◯ Female ◯

Mailing Address (Mail will be sent to this address)	City	Province	Postal Code

Daytime Phone Number	Fax Number	Email Address

Office Address (If applicable)	City	Province	Postal Code

Office Phone Number	Office Fax Number

Education And Licensing Information

Original Degree Granting University (MD)	Location	Graduation Year	CPSNS License Number

Specialty Received

CCFP ☐ CAC ☐ FRCSC ☐ FRCPC ☐

Other ☐ _____

Date of Certification

Day Month Year

Type of Practice/Submitter Information

Please enclose a 'letter of intent' detailing your plans to practice in Nova Scotia (Full/Part time/Locum/Joining Group/Fee for Service/Contract).

*Submitter Name	Submitter Email Address	**Submitter ID (3 Letters)

*Individual or organization accredited by MSI to submit electronic service encounter transactions on a provider's behalf.
**Unique identifier assigned to the submitter by MSI.

Declaration

I declare the information provided on this application to be true and I consent to allow MSI to verify, with other sources, all information I have given in this application. These sources may include but are not limited to the Governing Body of my related Health Profession (e.g., College of Physicians & Surgeons of Nova Scotia) and the medical school indicated on my application.

I understand that in applying for and subsequently receiving my physician billing number that I am subject to the provisions of the Health Services and Insurance Act (HSIA), Regulations under the HSIA, the Schedule of Benefits, Preamble and all Physician's Bulletins, as well as any amendments or updates thereto. It is my responsibility to read and understand the information contained in the HSIA (https://nslegislature.ca/sites/default/files/legc/statutes/healthsi.htm), its Regulations (https://novascotia.ca/just/regulations/regs/hsimsi.htm), the Schedule of Benefits (https://msi.medavie.bluecross.ca/physicians-manual/), and all Physician's Bulletins (https://msi.medavie.bluecross.ca/physicians-bulletins/).

I understand that it is my responsibility to comply with the HSIA, its Regulations, the Schedule of Benefits, and all Physician's Bulletins, as well as any amendments or updates thereto, and that all claims must be submitted in accordance with them. I acknowledge that only claims for services provided directly by me may be submitted under the physician billing number assigned to me, and that I am solely responsible for the accuracy of those claims, regardless of who may prepare and/or submit claims for those services on my behalf or how payment is made. I understand that all submitted claims must be verifiable from the patient records associated with the services claimed. I understand that all claims may be subject to pre-payment assessment or post payment audit. It is a provincial offense to contravene the HSIA or any of its Regulations.

I understand that as a health information custodian I am required under the Personal Health Information Act, 2013 to take steps that are reasonable in the circumstances to ensure that personal health information in my custody and control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing that information are protected against unauthorized copying, modification or disposal. I further understand that the obligation applies in connection with personal health information that I receive from or submit to MSI in connection with my billings.

Signature _____ Date _____

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Bank Information

*** ONLY BANKING INFORMATION FROM CANADIAN INSTITUTIONS WILL BE ACCEPTED**
*** A LINE OF CREDIT ACCOUNT WILL NOT BE ACCEPTED**

Name of Financial Institution

Bank Account Information

Bank Number (3 digits)	Branch Number (5 digits)	Account Number

*** PLEASE ATTACH A VOID CHEQUE OR DIRECT DEPOSIT FORM (COPY ACCEPTED)**

Authorization

I hereby authorize Nova Scotia Medical Services Insurance to make deposits to my account at the financial institution described above. I will advise MSI of any changes in my account information. I certify that the information given on this application form is accurate.

Signature _____ Date _____

Submit Your Application

By mail:	By Fax:	By email:
MSI Provider Management PO Box 500 Halifax NS B3J 2S1	902-469-4674 1-877-910-4674	msiproviders@medavie.ca Email should not be used when sharing personal/confidential information.

For questions, please call 902-496-7011 or 1-866-533-0585 (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.