NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

NOVA SCOTIA

# REQUEST FOR PRE-PAYMENT ASSESSMENT REVIEW

To: MSI Appeals Coordinator
MSI, P.O. Box 500, Halifax, NS B3J 2S1
MSI_AppealsCoordinator@medavie.ca

From: _____
Physician (Please print full name)

**Take Notice** that I am referring the "Result" of MSI, Service Encounter # _____

**Further Take Notice** that the particulars of the "Result" being contested are:

**On the following grounds**:

My email or mailing address for correspondence is:

_____

_____

Dated this _____, day of _____, 20__.

_____
Signature of the physician

_____
Physician Name

_____
Physician MSI Billing Number

Note: Upon receipt, the MSI Appeals Coordinator will forward a copy of this Request for Pre-Payment Assessment to the DHW and DNS