Medical Services Insurance (MSI) Predetermination Form for Arm & Leg Prostheses

Name____Date of Birth_____/____/____
Day Month Year

Address____Postal Code________________

Preferred Telephone Number ____

Nova Scotia MSI Health Card Number (10-digit number) _______________________________________

Prosthetist information:

Company Name: ____ Date: ________________________________

Company Address: ____ Company Tel #: _______________________

Signature of Prosthetist: ____ Company Fax #: _______________________

Requirements

Estimates must be submitted to Medavie Blue Cross/MSI for a predetermination and approval prior to submitting an invoice for payment.

Only pre-approved invoices will be paid and must accompany the resident's/patient's signature.

Invoices must be submitted within 12 months of the date of service to be considered for payment.

Changes to the original predetermination must be resubmitted for prior approval before submitting the invoice for payment.

- ☐ Complete and submit the predetermination form along with an estimate to the address or fax number below.
- ☐ Eligibility for the program is based on the resident having a valid Nova Scotia health card and requires the use of a conventional arm and/or leg prostheses based on the opinion of a physician as determined by a validated assessment.
- ☐ Services must be provided by a prosthetist certified by the Orthotics Prosthetics Canada and approved by Medavie Blue Cross/MSI on behalf of the DHW.
- ☐ Reimbursement is restricted to the maximum tariff agreement and residents who receive benefits that exceed the maximum tariff amount must acknowledge they are responsible for the additional costs.

Contact Information:

Mailing Address:	Ancillary Programs c/o MSI Assessment Department PO Box 500, Halifax, NS B3J 2S1	Phone: Toll Free: Fax:	(902) 496-7011 1-888-894-5353 (902) 490-2275

Statement of Information Accuracy: I understand reimbursement for prosthetic arm and leg claims covered by MSI are restricted to the maximum tariff amount and I accept responsibility for any remaining balance above the predetermined amount set by MSI and will make the appropriate payment set out by my service provider.

Resident/Patient Signature____Date__________________________