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

NOVA SCOTIA

PHYSICIAN APPLICATION

SECTION A —PHYSICIAN INFORMATION

Surname:	Given Name & Initials:	Date of Birth:	Day	Month	Year
		Sex	M ☐		F ☐

Country of Birth:	If Canada − which Province:
Business Address (Mail will be sent to this Address): Postal Code:	**Office Address:** (If applicable): Postal Code:
Telephone Number:	Telephone Number:
Fax Number:	Fax Number:
Email Address:	Email Address:

SECTION B —EDUCATION AND LICENSING INFORMATION

Original Degree Granting University (MD):	Location:	Graduation Year:	NS College License Number:

Specialty Received:				Date of Certification:		
☐ CCFP	☐ FRCSC			Day	Month	Year
☐ CAC	☐ Other					
☐ FRCPC						

SECTION C —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 ID (3 Letters)***:	

SECTION D — 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:** .....