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

NOVA SCOTIA

General Practitioner, Specialist
& Psychiatrist Claim Form

MSI USE ONLY:	
RECEIVED:	
ENTERED:	
PAYMENT DATE:	

ATTN:
Locum Program
PO Box 500
Halifax, NS B3J 2S1
Tel: (902) 496-7104

Via fax to: (902) 496-3060 (Local)
1-855-350-3060 (Toll Free)

Via email to: Locumprogram@medavie.ca

LOCUM PROVIDER	PROVIDER/GROUP #	DATES WORKED:

FACILITY NAME:

TYPE OF PAYMENT:	DAYS/HOURS/KM	X	RATE	=	AMOUNT:
LOCUM DAILY RATE GP*			$1,200.00		$0.00
LOCUM DAILY RATE SP**			$1,600.00		$0.00
LOCUM PER DIEM			$100.00		$0.00
LOCUM MILEAGE			$0.5838		$0.00
LOCUM DRIVE TIME			$100.00		$0.00
LOCUM ACCOMMODATIONS (Receipt Required)			$1.00		$0.00
LOCUM FLIGHT COST (Receipt Required)			$1.00		$0.00
LOCUM CPSNS LICENSING FEE (Receipt Required)			$1.00		$0.00
OTHER			$1.00		$0.00
				TOTAL:	$0.00

***GP = General Practitioner Rate; **SP = Specialist Rate**
****See guidelines for details**

Rates effective for dates of service April 1, 2024 to March 31, 2025

TRAVEL DETAILS:

DATE	FROM	TO	KILOMETRES

Release of payment is subject to receipt of shadow billing. **TOTAL:** 0.00

SIGNATURE OF CLAIMANT:	DATE:
X	

HOST PROVIDER/GROUP NAME:	PROVIDER/GROUP #	DATES WORKED:

FACILITY NAME:

OTHER SERVICES PROVIDED ON DATES WORKED:

All services eligible for additional compensation provided on the same day as receiving a locum daily rate (either half day or full day) must be identified here. *Additional space is available on page 2 if needed.*

☐ Office Practice [dates] _____
☐ Inpatient [dates] _____
☐ Primary Maternity Care [dates]_____
☐ Nursing Home [dates] _____
☐ Emergency Dept [dates] _____
☐ Other (specify)[dates] _____

MSI USE ONLY

TYPE OF PAYMENT:	DAYS	X	RATE	=	AMOUNT:
LOCUM OVERHEAD			$250.00		$0.00
				TOTAL:	$0.00

PAYMENT AUTHORIZED BY:	DATE:

ADDITIONAL INFORMATION: