

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