On March 19th, 2018 the Premier of Nova Scotia announced an enhanced fee for both office and geriatric visits for family physicians who are responsible for the comprehensive and continuous care of their patients. The enhanced fees are meant to differentiate this level of care from episodic care provided to walk-in patients. The enhanced fees are only available to family physicians who attest that they are providing comprehensive and continuous care. The letter below is a confirmation letter that all family physicians who intend to use, or have been using, the enhanced fees, are required to submit in order to continue to be eligible to bill these enhanced fees.

Please return this letter directly to MSI via email. Please send to:

primary_care_investments@medavie.bluecross.ca

Physician Confirmation Letter:

I am a Family Physician, licensed to practice in Nova Scotia. I provide full scope Family Medicine to my patients. By "full scope", I mean that I have an ongoing relationship as a primary care provider to my patients and ensure continuity in their medical care. My patients would describe me as their "family doctor" and my patients schedule appointments to see me.

The primary health care record (chart) for each of my patients is in my possession and where appropriate it is also accessible to colleagues in my practice who may share the responsibility for providing care to my patients in my absence. On occasion, other Family Physicians in my community and/or in my practice may see my patients when I am absent from my office. Whenever possible and appropriate, I assist or direct my patients to care when my office is closed or when I am unavailable. While I may accept walk-in patients from time to time, my primary practice is not providing episodic care to walk-in patients.

I understand and acknowledge that the enhanced office and geriatric visit fees do not apply to episodic care provided to walk-in patients for whom neither I nor my practice are the patient's primary care provider.

☐ By checking this box, I certify that the statements above apply to me and my practice.

Name: _____

Billing #: _____

Date: _____