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

NOVA SCOTIA

Assistance for Cancer Patients Program

Wig Claim Form

To access wig coverage, residents need to be enrolled in the Assistance for Cancer Patients Program

PATIENT

Health Card Number: ____________________

Last Name: ____________________ First Name: ____________________

Address: ____________________ Apt. No.: ____________________

City/Town: ____________________ Province: ____________________

Postal Code: ____________________ Telephone No.: ____________________

Please attach receipt to claim form.

SUPPLIER

Name: ____________________ Location (if applicable): ____________________

Date of Purchase: ____________________ Total Price: $____________________

Residents will be reimbursed up to $300 for the one-time purchase of a wig.

PATIENT'S CERTIFICATION

I ____________________ declare this to be a true statement of services received from the
(patient's signature)
Above named supplier and authorize MSI to send payment directly to:

Pay Provider: ☐ Pay Patient: ☐

Date: ____________________

Return this form to:

MSI Programs
BTO Program
PO Box 500
Halifax, NS B3J 2S1

Toll free: 1-888-894-5353
or 1-902-496-7011
Fax: 1-902-490-2275