Fife Health & Social Care Partnership

FIFE PHARMACY

NHS Fife

Claim Form for Payment of Out-of Hours Supply of Palliative Care Medicines

Date of Claim ………………….. **Name of Pharmacy**…………………………………….

Name & Home Address of Pharmacist ……………………………………………..
……………………………………………..
……………………………………………..
……………………………………………...

Pharmacist's National Insurance Number*…………………………………………

Details of Supply:
Date……………….. **Time**………………
Delivery Location………………………………..
Personnel to who supply was made (E.g. GP (name) , District Nurse, Patient etc) (name)…………………………
Appropriate Rx available **Yes** ☐ **No** ☐

Medicines Supplied

Amount Claimed:

		Total
Call-out Fees Claimed (£100 per call-out)		
Mileage Claimed (40p per mile)		
	Total Claimed	

Pharmacists Bank Account Number	
Pharmacists Bank Sort Code	

Please return this form to: Fife-UHB.fifepharmacycommpharm@nhs.net
or
Pharmacy Services
Pentland House
Lynebank Hospital
Dunfermline,
KY11 4UW

Claim Form authorised by ……………………………………………………..
Designation …………………………..
Financial Code………………..

***This payment requires to have Tax deducted.**