Community Pharmacy

Hepatitis C Medication Provision

Claim Form

Pharmacy Name & Address

Date treatment commenced	
Medication Prescribed	
Intended length of treatment	
Supervised?	
Name of Pharmacist making claim	
Signature or GPhC Number of Pharmacist	
Contractor Code	
Date	
Amount Claimed	**£390.00**

Please return the completed claim form to:
Send completed form by email to fife.fifepharmacycommpharm@nhs.scot

For office use only.

Claim form authorised……for Pharmacy Services

Date……..

Financial code…….