FIFE PHARMACY

NHS Fife

COMMUNITY PHARMACY
HEPATITIS C
CLAIM FORM for ADVANCED PAYMENT OF MEDICINES

Pharmacy Name & Address

Contractor Code	
Patient CHI No.	
Date treatment commenced	

Name of Medicine	**Duration**	**Quantity**	**Cost exc VAT**

Note: Please do not claim advanced payment for Ribavirin

Authorised signatory (or GPhC number) for participating pharmacy: ..... **Date**.....

Please print name: .....

Authorised Signatory for Blood Borne Virus Service: .....**Date**.....

Financial Code: .....

Completed form to be emailed to fife.sexualhealthreferrals@nhs.scot **by 5th of Calendar Month**
Please note advanced payment will be reclaimed 6 months after payment