APPENDIX 2 - PSD CLAIM FORM

Stoma Appliance Claim Form
To be completed each month for which payment is claimed

Supplier Name and address:

Supplier Code:

Month:	Year:

I the undersigned Supplier confirm that I have complied with all the requirements detailed in the

"SPECIFICATION OF REQUIREMENTS FOR DISPENSING AND SUPPLY OF STOMA APPLIANCES TO PATIENTS IN THE COMMUNITY FOR NHS SCOTLAND APPLICABLE FROM: 1ST JULY 2016 TO 30TH JUNE 2018"

and hereby claim customisation and delivery fees applicable to the provision of the patient service elements of Stoma Appliances during the month stated above.

Monthly Number of Stoma Items dispensed:

Monthly Number of Customisation Fees claimed:

Monthly Number of Delivery Fees claimed:

Counterfraud Declaration

I declare that the information I have provided is correct and complete. I understand that, if I knowingly provide false information, this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I agree that any overpayments indentified though the post payment verification process may be recovered at a future date by the Common Services Agency for the Scottish Health Service. For the purposes of payment verification, I consent to the disclosure of information from this form to and by the Common Services Agency and the Health Board within which any patient for which I dispense is domiciled and agree to co-operate fully with all payment verification procedures.

Signature:……..... Date:……

Name: ……. Company Position:……..

Send the completed form either:

1. By post to: Pharmacy Payments
NHS National Services Scotland
Practitioner Services
Gyle Square
1, South Gyle Crescent
Edinburgh EH12 9EB

2. By email NSS.psd-cp-claims@nhs.net