FORM PCD/ADM14A

COMPLIANCE AID CLAIM & REIMBURSEMENT FORM

Claim for the month of:-_____

Year:- _____

Contractor code

Pharmacy Details/Stamp

A SEPARATE FORM MUST BE USED FOR EACH MONTH AND MUST BE SUBMITTED ON A MONTHLY BASIS

Type of device supplied

Patients receiving monitored dosage system assessed/reviewed suitable under frail elderly – Annex A enclosed

Total number of patients	
Total number of weeks claimed for	
Total cost for month @32p per pack	

Patients receiving monitored dosage system assessed/reviewed suitable under severe and enduring mental illness – Annex B enclosed

Total number of patients	
Total number of weeks claimed for	
Total cost for month @32p per pack	

TOTAL CLAIM FOR MDS = _____ @ £0.32 =

_____

TOTAL REIMBURSEMENT CLAIMED **£**

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Pharmacist Name_____

Signature_____ Date_____

Please complete and return by the **7th of the month** to: Diane Robertson,
Pharmacy Department, Kings Cross Hospital, Clepington Road, Dundee, DD3 8EA
Contact for queries – Tel 01382 835151

NB Claims for more than 3 months in arrears will not be processed

For Office Use Only Financial Code	Approved for Payment	
	Name	Date

FRAIL/ELDERLY CLAIM: Month _____ Year _____

CONTRACTOR CODE: _____

Patient's initials/ Pharmacy identifier number	GP practice code	Number of weeks claimed	Assessment date	Last review date	Reviewed by (name of pharmacist)

Total number of weeks claimed:- _____

SEVERE & ENDURING MENTAL ILLNESS CLAIM: Month _____ Year _____

Patient's initials/ Pharmacy identifier number	GP practice code	Number of weeks claimed	Assessment date	Last review date	Reviewed by (name of pharmacist)

CONTRACTOR CODE: _____

Total number of weeks claimed:- _____