Appendix 1

Multi-Compartmental Compliance Aids(MCA) Reimbursement Process Application Form

Pharmacy Name: _____ Contractor Code: _____

Address: _____

_____

_____

Postcode: _____

Current number of patients receiving monitored dosage devices (Please do not include patients in Care Homes) [ ]

- I undertake to submit my MCA Reimbursement claim form. On the 10th of each Month to CommunityPharmacy.Contract@nhslothian.scot.nhs.uk
- I understand I will be reimbursed at the costs agreed in the claim form.
- I declare that the above number represents patients who are currently not resident in a Nursing/Care Home and will be used as a baseline for future monthly claims.
- I undertake to accurately record the number of new patients referred and details of the referrer each month.
- I undertake to retain a copy of invoices for all MCAs claimed for review when required by a representative of the Health Board for payment verification purposes

I declare that the information given on this form is correct and complete. I understand that if I knowingly provide false information, this may lead to action being taken against me. For the purpose of verification of these claims and the prevention, detection and investigation of crime, I consent to the disclosure of relevant information on this form including to and by the Common Services Agency.

Form completed by: *(Please print full name)* _____ Date: _____

Signature: _____

Please return completed form by 22nd April to Katie Kerr, PCCO, Pentland House, 47 Robb's Loan, Edinburgh, EH14 1TY