**Appendix 2**

# COMMUNITY PHARMACY PAYMENT CLAIM FORM

**DoxycyclineTreatment of Uncomplicated Chlamydia Infection or NGU**

Please complete this form on a monthly basis and either return by e-mail to: ChalmersHealthAdvisers@nhslothian.scot.nhs.uk

**OR**

 Post along with any paper treatment vouchers to:

 Health Advisers, Chalmers Centre, 2a Chalmers street, Edinburgh EH3 9ES

NB: NO PAYMENT CAN BE MADE WITHOUT THE TEXTED UNIQUE VOUCHER NUMBERS OR THE PAPER VOUCHERS

Please enter text voucher numbers below

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| --- | --- | --- | --- |
| **Service provided** | **Fee applicable** | **No of times service provided month of claim** | **Total claimed****(£)**  |
| Provision of treatment | £5.00 |  |  |

**Name of participating pharmacy:**

**Address:**

**Phone Number:**

**E-mail address: Pharm.CP**

**Date:**

**Authorised signatory for participating pharmacy:**

**Print name: Signature:**

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Payment authorised by:

Cost Centre/ account code:

Name:

Business manager, Chalmers Centre

Date:

**COMMUNITY PHARMACY PAYMENT CLAIM FORM**

**Treatment of uncomplicated Chlamydia Infection or NGU**

**TEXTED UNIQUE VOUCHER NUMBERS (CONTINUED)**

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