

**PROSTATE CANCER AUDIT/CLAIM FORM**

**Contractor Stamp:**

**Contractor Code**: …………...............

**I confirm that:**

* I am claiming for reimbursement for participating in the above service.
* For the purposes of payment verification, the service has been provided in line with the service specification.
* I am claiming the annual payment of **£75** for the service provided to the patient who started their treatment on (date): .............................................................

Pharmacist signature……………………………… Date………………….

**Please return the completed Claim Forms by email to:** **aa.cpteam@aapct.scot.nhs.uk** **or by post to: Pharmacy and Prescribing Team, Eglinton House, Ailsa Hospital, Dalmellington Road, AYR KA6 6AB.**

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**For office use only**

Contractor code................................ Total Amount for payment **£75**

Cost Centre....................................... Authorised by…………………………………