

**HEPATITIS C SERVICE CLAIM FORM**

**Contractor Stamp:**

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

**I confirm that:**

* I am claiming for reimbursement for participating in the above service for a new patient and have provided the stated level of service to the patient as outlined in the service specification.

**Patient Start Date:** \_\_/\_\_/\_\_\_\_

* For the purposes of payment verification the appropriate assessments for the patients are available within the pharmacy if required by NHS Ayrshire and Arran

**Patient Number:** …………. **Patient Initials:** ……

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

**Please return completed Claim Forms by email to** **aa.cpteam@aapct.scot.nhs.uk**

**For office use only**

Contractor code................................ Total Amount for payment **£400**

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