**Appendix 4**

**Opt In for Hepatitis C Advance Payments**

The pharmacy contractor detailed below wishes to **OPT IN to the advanced payment for the Hepatitis C SLA.** Complete and sign this document and submit a copy to: gram.pcctpharmacy@nhs.scot (retain a copy for your records)

|  |
| --- |
| **Pharmacy contractor details** |
| Pharmacy name |  |
| Pharmacy address |  |
| Name of person completing form |  |
| Role of person completing form |  |

|  |
| --- |
| **Declaration**I declare that the information I have given on this form is correct and I understand that if it is not, action may be taken against me. I acknowledge that this information will be authenticated from appropriate records, and that any payment made to my pharmacy based on this information, will be subject to Payment Verification. Where NHS Grampian is unable to obtain authentication, I acknowledge that the onus is on my pharmacy to retain and provide, when requested, documentary evidence to support the information provided  |
| **Signed** |  |
| **Date** |  |