Community Pharmacy

Hepatitis C Medication Provision

Claim Form

Pharmacy Name & Address

Date treatment commenced	
Medication Prescribed	
Intended length of treatment	
Supervised?	
Name of Pharmacist making claim	
Signature or GPhC Number of Pharmacist	
Date	
Amount Claimed	**£390.00**

Please return the completed claim form to:
Send completed form by email to fife-uhb.fifepharmacycommpharm@nhs.net

or post to

Sheila Dall
Pharmacy Services
Pentland House
Lynebank Hospital
Halbeath Road
Dunfermline
KY11 4UW

For office use only.

Claim form authorised……for Pharmacy Services

Date……..

Financial code……..