

Monitored Dosage System (MDS)

Claim Form

Pharmacy Name and Address

Contractor code

Number of patients (excluding those in care homes) pharmacy is providing with MDS devices.

Date of claim	Supplier	Number of devices purchased	Total amount of claim (excl VAT)

I certify that, to the best of my knowledge, approved MDS trays were supplied to patients who are not resident in a residential care or nursing home. I hereby claim reimbursement for the MDS devices purchased.

I declare that the above information is correct and complete and I have provided the items claimed for and I have **attached a copy of the supporting invoice**.

Counter Fraud Declaration: I accept that the information provided on this form may be used to verify the claim and may be shared with other bodies/agencies for the purposes of prevention and detection of crime. In signing this form, I consent to this use and acknowledge that if I provide false information then I may be liable to criminal prosecution, referral to my professional body and/or recovery proceedings.

Signature

Position Date

Please return to: Carol Droubay, Pharmacy Contracts Officer
 Primary Care Contractor Services
 NHS Forth Valley
 Suite 2, Carseview House
 Castle Business Park
 Stirling, FK9 4SW

Or by e-mail: carol.droubay@nhs.net

For NHS use:

Authorised by: _____

Date: _____

Amount paid: _____

Date: _____