**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: \_\_\_\_\_\_\_\_\_\_\_\_\_