

PHS Claim Form

Contractors claiming the following monthly payments:

- PHS – Smoking Cessation Capitation Payments
- PHS - Chlamydia Capitation Payments
- PHS – Sexual Health Capitation Payments

must comply with the Claim Form requirements:

Print it off and post it to:

Moira Hanley
NHS National Services Scotland
Practitioner Services
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

e-mail: NSS.psd-cp-claims@nhs.net

PUBLIC HEALTH SERVICE (PHS) CLAIM FORM
TO BE COMPLETED EACH MONTH FOR WHICH PAYMENT IS CLAIMED

Contractor Name

Contractor Code

Date of services provided

I the undersigned contractor confirm that I have complied with all the requirements detailed in NHS Circular PCA(P) (2008) 17 related to the provision of the patient service elements of PHS - Smoking Cessation and PHS - Sexual Health and hereby claim capitation payments for the following numbers of patients to who I have provided treatment during the month stated above.

PHS - Smoking Cessation
No. of patients in month 1 of treatment during month of claim

No. of patients in month 2 of treatment during month of claim * complete only if these patients registered for 1 month

No. of patients in month 3 of treatment during month of claim * complete only if these patients registered for month 1 + 2

PHS - Sexual Health Part A - Chlamydia Services
No. of patients treated during month of claim

PHS - Sexual Health Part B - Emergency Hormonal Contraception (EHC)
No. of patients treated during month of claim

I confirm that I have completed and submitted to the Health Board all necessary national minimum dataset forms for patients receiving treatment for smoking cessation for the claimed month. I advise that the PHS – Sexual Health Part B – EHC patient service has been available during the standard contracted opening hours of this community pharmacy for the claimed month.

COUNTERFRAUD DECLARATION

I declare that the information I have provided is correct and complete. I understand that, if I knowingly provide false information, this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I agree that any overpayments identified through the post payment verification procedure may be recovered at a future date by the Common Services Agency for the Scottish Health Service. For the purposes of payment verification, I consent to the disclosure of information from this form to and by the Common Services Agency and the Health Board on whose pharmaceutical list I am listed, as a contractor and agree to co-operate fully with all payment verification procedures.

Signature:

Name:

Company position: Date.....