PRESCRIPTION_ CLAIM FORM

FORM NO. 004/683

GJ

DATE DISPENSED	DAY		MONTH		YEAR			
	1	4	0	4	2	0	2	0

SCHEME TYPE DRUG REFUND SCHEME

PATIENT NAME NICHOLAS MOUNEY

PATIENT ADDRESS

PATIENT REFERENCE No.

PRESCRIBER NAME Dr. Walk In r:Ator

PRESCRIBER ADDRESS

PRESCRIBER NO.

DRUG NAME AND STRENGTH	DRUG CODE	QUANTITY DISPENSED	COST
FUCIDIN H 20MG/G + 10MG/6 CREAM 20MG/G/10MG/G (LE: PHARMA] (30)	9 4 9	3 0	17.6
TOTAL PAID BY/OR ON BEHALF OF PATIENT			17.hr

Complete the foilwwi g oniy if you are laking a claim under tre drug reford scl-ele.

Claiilant Naae

laiilant Add ess

I verifv t at t e catient received the qualtity of lteis stated above.

Relationship of Claiia t to Patie:--t

Claiiant Signatu e

Duffy's Pharmacy 11877

Mary Jo Duffy
B.Sc. Pharm. M.P.S.I.
GMS. No. 11877

14 APR 2020

Tesco Shopping Centre
Ennis, Co. Clare.
Tel. 828833

PHARMACY STAMP

GMS007
8079

RECEIVED BY: ______

To be signed by patient (or representative)