**South West**

**B&NES, Gloucestershire, Swindon & Wiltshire Team**

Appendix A – Claim Form and information for audit – Access to medicines Out of Hours (2020 – 2021) NB: No claim can be entertained in respect of hours of service provided not required specifically by the Scheme.

|  |
| --- |
| Name of pharmacy: ……………………………………………. OCS code: ………………….  Address of pharmacy: ……………………………………………………………………………. |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Number of patients that have come via** | | **Number of prescription items** | | | | **Number of patients receiving advice that also bought** | |  |  |
| **Time** | **Walking into the store** | **No of Patients Directed from Out of Hours/111** | **Number of prescription forms dispensed (exempt)** | **Number of prescription forms dispensed (paid)** | **Number of prescription items dispensed (exempt)** | **Number of prescription items dispensed (paid)** | **Pharmacy Medicines** | **GSL Medicines** | **Number of patients / Healthcare professionals given advice** | **Number of patients / Healthcare professionals**  **signposted to other services** |
| 07:00 - 08:00 |  |  |  |  |  |  |  |  |  |  |
| 08:00 - 09:00 |  |  |  |  |  |  |  |  |  |  |
| 09:00 - 10:00 |  |  |  |  |  |  |  |  |  |  |
| 10:00 - 11:00 |  |  |  |  |  |  |  |  |  |  |
| 11:00 - 12:00 |  |  |  |  |  |  |  |  |  |  |
| 12:00 - 13:00 |  |  |  |  |  |  |  |  |  |  |
| 13:00 - 14:00 |  |  |  |  |  |  |  |  |  |  |
| 14:00 - 15:00 |  |  |  |  |  |  |  |  |  |  |
| 15:00 - 16:00 |  |  |  |  |  |  |  |  |  |  |
| 16:00 - 17:00 |  |  |  |  |  |  |  |  |  |  |
| 17:00 - 18:00 |  |  |  |  |  |  |  |  |  |  |
| 18:00 - 19:00 |  |  |  |  |  |  |  |  |  |  |
| 19:00 - 20:00 |  |  |  |  |  |  |  |  |  |  |
| 20:00 - 21:00 |  |  |  |  |  |  |  |  |  |  |
| 21:00 - 22:00 |  |  |  |  |  |  |  |  |  |  |

**For the month of…………………………….2020/2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Open from**  **\*(state am/pm)** | **Open to**  **\*(state am/pm)** | **Payment**  **(per hour)** | **Total** |
|  |  |  |  |  |
| **TOTAL CLAIM** | | | |  |

I (we) declare that the premises listed above was open in accordance with requirements of the Access to Medicines Out Hours of Service Scheme on the dates and at the times shown. I (we) confirm that the information given on this form is true and complete. I understand that if I provide false or misleading information I may be liable to prosecution or civil proceedings. I understand that the information on this form may be used for the purpose of fraud prevention, detection and investigation.

|  |
| --- |
| Name of Duty Pharmacist (print): ……………………………………………………………….  Signature of Duty Pharmacist: ………………………………………………….. Date: ………………….. |

Claims and activity monitoring data should be submitted to the NHS England & Improvement South West, BGSW Primary Care Team at [england.bgsw-pharmacy@nhs.net](mailto:england.bgsw-pharmacy@nhs.net) on the 1st of each month.