Appendix 5

GLUTEN-FREE FOOD SUPPLY
PATIENT'S MONTHLY ORDER FORM

Patient Initials ONLY:

Patient Exemption Y or IFR reference number

Evidence seen: Y / N

Date Review due: **Max Units Allowed**

	To be completed by Patient	To be completed by dispensary staff				
Item No	**Product Description**	**Quantity**	**# Units**	**List Price**	**Qty x List Price**	**Total Cost / item**
1						
2						
3						
4						
5						
6						
			Total			
					Total cost of items	
					Administration Fee	
					Total cost Claimed	

Please sign for receipt of your order:

Signature: **Date:**

Please remember to collect your order form for next month.

NHS Bedfordshire Luton and Milton Keynes ICS

PHARMACY / DISPENSARY USE ONLY

Pharmacy / Dispensary Stamp

This Claim is for the month of …… Invoice no: ……

Please ensure forms are completed in full for each patient.
The pharmacy is responsible for ensuring the completion of the patient declaration on page 2.
A copy of this order form must be submitted with a copy of your invoice to
the BLMK ICS Medicines Optimisation Team
FAO GLUTEN FREE blmkccg.bedsmeds@nhs.net
The exemption declaration on page 2 must **not be submitted** to the Medicines Optimisation Team.

GLUTEN-FREE FOOD SUPPLY
PATIENT'S MONTHLY ORDER FORM
page 2

Gluten Free Supply Payment / Exemption Declaration

Patient declaration of exemption from charges. This must be completed each time a supply is made.

The patient does not have to pay because he/she:

A is under 16 years of age

B is 16, 17 or 18 and in full time education

You're also entitled to free prescriptions if you or your partner (including civil partner) receive, or you're under the age of 20 and the dependant of someone receiving:

C Income Support

D income-based Jobseeker's Allowance

E income-related Employment and Support Allowance

F Pension Credit Guarantee Credit

G Universal Credit and meet the criteria

If you're entitled to or named on

H a valid NHS tax credit exemption certificate

F a valid NHS certificate for full help with health costs (HC2)

Declaration: I declare that the information I have given on this form is correct and complete. I understand that if not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by the Prescription Pricing Authority, the NHS Counter fraud and security Management service, The Department for Work and Pensions and Local Authorities.

Name:

Address:

Sign _____ Date _____/_____/_____

I am the Patient ☐ the Patient's representative ☐