GLUTEN-FREE FOOD SUPPLY PATIENT'S MONTHLY ORDER FORM

Patient Initials ONLY:					
Patient Exemption Category (see Page 2) Evidence seen: Y/N					
OR F	Prior Approval reference number				
Date	Date Review due: Max Units Allowed				
	To be completed by Patient				
Item	Product Description				
1					
2					
3					
4					
5					
6					
Pleas	se sign for receipt of your order:				
 					
Signature: Date:					
Please remember to collect your order form for next month.					

PHARMACY / DISPENSARY USE ONLY

Pharmacy / Dispensary Stamp				
This Claim is for the month of	Invoice no:			

To be completed by dispensary staff					
To be completed by dispensary staff					
				Total Cost of	
Quantity	# Units	List Price	Qty x List Price	item	
	Total		Total cost of items		
		_			
			Administration Fee		
			Total cost Claimed		

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 blmkics.medsopt@nhs.net

The exemption declaration on page 2 must **not be submitted** to the Medicines Optimisation Team.

GLUTEN-FREE FOOD SUPPLY

NHS Bedfordshire Luton and Milton Keynes ICS

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 use this service 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
- Universal Credit and meet the criteria
 - If you're entitled to or named on
- H a valid NHS tax credit exemption certificate
- a valid NHS certificate for full help with health costs (HC2)

Note to Pharmacy - you must indicate which exemption applies on Page 1 of this form

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 \square the Patient's represer	n the Patient \square the Patient's representative \square				