GLUTEN-FREE FOOD SUPPLY

PATIENT'S MONTHLY ORDER FORM

	nt Exemption Category (
DR F	rior Approval reference r	number	
Date	Review due:	view due: Max Units Allow	
	To b	e completed by	Patient
tem	Product Description		
1			
2			
3			
4			
5			
6			

PHARMACY / DISPENSARY USE ONLY

Pharmacy / Dispensary Stamp

This Claim is for the month of Invoice no:

	То	be completed b	y dispensary staff	
			<u> </u>	Total Cost of
Quantity	# Units	List Price	Qty x List Price	item
	Total		Total cost of items	
			Administration Fee	
			Administration ree	
			Total cost Claimed	4
pharmacy is			ted in full for each patient pletion of the patient decla	
			tted with a copy of your in	
	the BL	MK ICS Medicines	Optimisation Team	
AO GLUTEN	FREE blmkic	s.medsopt@nhs.n	et WITHIN 3 MONTHS O	F DISPENSING
he declaratio	on on page 2 n	nust not be submit t	ted to the Medicines Optim	misation Team.

Signature: Please remember to collect your order form for next month.

NHS Bedfordshire Luton and Milton Keynes ICS

Date:

GLUTEN-FREE FOOD SUPPLY PATIENT'S MONTHLY ORDER FORM

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Gluten Free Supply Eligiblity Declaration

	Sidten Tree Supply Englandy Declaration					
	Scheme.					
This must be completed each time a supply is made.						
	The patient is eligble to receive Gluten Free Breads and mixes free of					
charge because they:						
A	are under 16 years of age					
В	are 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:					
С	Income Support					
D	income-based Jobseeker's Allowance					
Е	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					
н	a valid NHS tax credit exemption certificate					
I	a valid NHS certificate for full help with health costs (HC2)					
Note	e to Pharmacy - you must indicate which exemption applies on Page 1 of this form					
corr enti prev info Cou	claration: I declare that the information I have given on this form is correct and nplete. I understand that if not, appropriate action may be taken. I confirm proper tlement to eligibility. To enable the NHS to check I have a valid exemption and to vent and detect fraud and incorrectness, I consent to the disclosure of relevant rmation from this form to and by the Prescription Pricing Authority, the NHS unter fraud and security Management service, The Department for Work and asions and Local Authorities.					

Name:

Address:

Sign _____ Date ___/ __/

I am the Patient \Box the Patient's representative \Box