

Dear Colleague

**ADDITIONAL PHARMACEUTICAL SERVICES:  
PUBLIC HEALTH SERVICE (PHS) – UPDATED CLAIM  
FORM FOR PATIENT SERVICE PROGRAMMES**

**Summary**

1. This Circular advises community pharmacy contractors and Health Boards of an amendment to the Drug Tariff in respect of an updated claim form to be used by contractors providing the Public Health Service (PHS) patient services.

**Background**

2. [NHS Circular PCA\(P\)\(2008\)17](#) published on 22 August 2008 provided the service specifications and claim form for the PHS patient services. It also stated the requirement for contractors to complete and return to the Health Board the national minimum dataset for each patient receiving treatment for smoking cessation.

**Detail**

3. From 31 May 2010, community pharmacy contractors must use the updated claim form provided as an Annex to this circular for all patients treated under the PHS patient services.

4. The claim form now requires contractors to provide confirmation that they have completed and submitted a national minimum dataset form to their Health Board for each patient receiving treatment for smoking cessation that month.

5. There is no change to the claim arrangements for the PHS sexual health service of emergency hormonal contraception (EHC) and Chlamydia testing and treatment other than the requirement to use the new claim form.

12 May 2010

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**Addresses**

For action

Chief Executives, NHS Boards

For information

Chief Executive, NHS NSS

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**Enquiries to:**

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6. Community Pharmacy Scotland has been consulted on this amendment to the Drug Tariff.

**Action**

7. Health Boards are asked to note the contents of this Circular and to copy to their local pharmaceutical committee and all community pharmacy contractors.

Yours sincerely

**FRANK STRANG**  
Deputy Director

**CLAIM FORM COMMUNITY PHARMACY CONTRACTORS FOR PHS-PATIENT SERVICE PROGRAMMES**

TO BE COMPLETED EACH MONTH FOR WHICH PAYMENT IS CLAIMED

Contractors claiming the following monthly payments:

PHS – Smoking Cessation Capitation Payments  
PHS – Sexual Health Capitation Payments

must comply with the following requirements and return a copy of the completed form either:

By post to

Moira Hanley  
NHS National Services Scotland  
Practitioner Services  
Gyle Square  
1, South Gyle Crescent  
Edinburgh  
EH12 9EB

By fax to 0131 275 7532

Or by email [moira.hanley@nhs.net](mailto:moira.hanley@nhs.net)

The original must follow by post.

**Please Note:**

To be eligible for the timely processing with payments relating to the dispensing month concerned, Practitioner Services Division must receive forms **no later than the 7<sup>th</sup> day** of the following month. Forms received later than this date will be processed as claims relating to the following or subsequent month dependant on the date and month of receipt.

**PUBLIC HEALTH SERVICE (PHS) CLAIM FORM**

TO BE COMPLETED EACH MONTH FOR WHICH PAYMENT IS CLAIMED

Contractor Name

Contractor Code

Date of services provided

I the undersigned contractor confirm that I have complied with all the requirements detailed in NHS Circular PCA(P) (2008) 17 related to the provision of the patient service elements of PHS - Smoking Cessation and PHS - Sexual Health and hereby claim capitation payments for the following numbers of patients to who I have provided treatment during the month stated above.

**PHS - Smoking Cessation**

No. of patients in month 1 of treatment during month of claim

No. of patients in month 2 of treatment during month of claim

No. of patients in month 3 of treatment during month of claim

**PHS - Sexual Health Part A - Chlamydia Services**

No. of patients treated during month of claim

**PHS - Sexual Health Part B - Emergency Hormonal Contraception (EHC)**

No. of patients treated during month of claim

I confirm that I have completed and submitted to the Health Board all necessary national minimum dataset forms for patients receiving treatment for smoking cessation for the claimed month.

I advise that the PHS – Sexual Health Part B – EHC patient service has been available during the standard contracted opening hours of this community pharmacy for the claimed month.

**COUNTERFRAUD DECLARATION**

**I declare that the information I have provided is correct and complete. I understand that, if I knowingly provide false information, this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I agree that any overpayments identified through the post payment verification procedure may be recovered at a future date by the Common Services Agency for the Scottish Health Service. For the purposes of payment verification, I consent to the disclosure of information from this form to and by the Common Services Agency and the Health Board on whose pharmaceutical list I am listed, as a contractor and agree to co-operate fully with all payment verification procedures.**

Signature: .....

Name: .....

Company position: .....

Date: .....