HSC Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

PHARMACY FIRST Service for Emergency Hormonal Contraception (EHC): Monthly claim form

Pharmacy Contractor Number: _____						**Month & year of claim:** _____		
Patient demographics			**Medicine supplied** (tick all that apply)			**Consultation outcomes**	**Consultation fees claimed**	
Patient number	**Age** (years)	**Patient registered with GP practice in NI?** *(if no give details)*	**UPA-EC**	**LNG-EC**	**Desogestrel (POP)**	**Patient referred?** *(if yes give details)*	**EHC** (please tick)	**POP** (please tick)
Pharmacist name:			**Page number:**			**Total number of fees claimed**	___@ **£25**	___@ **£15**
Pharmacist signature:			____**of** ____			**Total payment claimed**	**£**	

Claim forms must be emailed to **local Primary Care offices** for processing and payment