PRESCRIPTION CLAIM FORM

FORM NO.

Scheme Type		**Date Dispensed**	
Patient Name		**Prescriber Name**	
Patient Address		**Prescriber Address**	
Patient Reference No.		**Prescriber No.**	

DRUG NAME AND STRENGTH	DRUG CODE	QUANTITY DISPENSED	COST
TOTAL PAID BY/OR ON BEHALF OF PATIENT			

Pharmacy

Pharmacy Stamp

RECEIVED BY: .....

To be signed by patient (for representative)