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| **PRESCRIPTION CLAIM FORM** | **FORM NO.** | **123456789** |

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| **Scheme Type** | Private Scheme | **Date Dispensed** | 15/03/2025 |
| **Patient Name** | Gregory Higgins | **Prescriber Name** | Dr. Krista Daniels |
| **Patient Email** | gregory.higgings1@email.com | **Prescriber** | Hangover Medical Centre |
| **Patient Address** |  | **Address** | Hangover Medical Centre |
|  |  |  | 5 Lazer Lane Dublin 2 |
|  |  |  | Dublin 2 |
| **Patient Reference No.** |  | **Prescriber No.** |  |

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| --- | --- | --- | --- |
| **DRUG NAME AND STRENGTH** | **DRUG CODE** | **QUANTITY** | **COST** |
| Ibuprofen | 53490 | 1 | $ 48.95 |
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| TOTAL PAID BY/OR ON BEHALF OF PATIENT |  |  | $ 48.95 |

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| Pharmacy  **Pharmacy Stamp** |

RECEIVED BY: -----------------------------------------------------------------------

To be signed by patient (for representative)