

SMOKING CESSATION SERVICE

RETURNS FORM

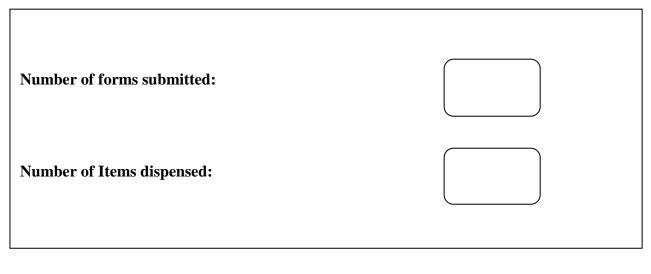
MONTH:

YEAR:

Contractor:

PSD Code:

Address:



CONTRACTOR SIGNATURE:

PRINT NAME: DATE:

I declare that the information I have given on this form is correct and complete and I understand that if it is not, action may be taken against me. I acknowledge that my claim will be authenticated from appropriate records, which will be subject to Payment Verification. Where Practitioner Services is unable to obtain authentication, I acknowledge that the onus is on the Contractor to provide documentary evidence to support this claim.

Please attach one form to each set of scripts before submitting to: A & C Office, *Pharmacy Department*, *BGH*, *MELROSE*, *TD6 9BS*.