SMOKING CESSATION SERVICE

RETURNS FORM

MONTH: **YEAR:**

Contractor: **PSD Code:**

Address:

Number of forms submitted:	
Number of Items dispensed:	

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.*