NHS

Prescription Services

ETP Monthly Allowance Claim Form

To:	PCT	Pharmacy or Company Stamp *(or if a head office attach a signed letterhead as authorisation)*

Contractor Account Details

ODS code/F Code	
Pharmacy Name	
Trading Name *(if different)*	
Address	
Postcode	

Contractor Declaration

I can confirm that the above named pharmacy contractor has:

i. an ETP compliant pharmacy system (accredited as such by NHS Connecting for Health)

Release 1 ☐ **OR** Release 2 ☐

ii. appropriate network connectivity to be able to operate the Electronic Prescription Service

iii. staff operating the service who are registered users and have been issued with smart cards and PIN numbers by their PCT's Registration Authority.

I hereby submit and make a claim for the monthly payments in accordance with the terms of the Electronic Prescription Service, as set out in Drug Tariff Part VIA Paragraphs 5.10 and 5.11, Electronic Transmission of Prescription Allowances.

I undertake to notify the PCT in writing immediately if at a later date the pharmacy is no longer able to operate the Electronic Prescription Service. I accept that NHS Prescription Services will make and stop these payments as authorised by the PCT.

Claim made by: *(authorised signature)*		**Telephone number:** *(in case of queries)*	
Name: *(please print name)*		**Position:**	
Date:			