Health and Social Care Board

MEDICINES ADHERENCE SUPPORT SERVICE (MASS) POST-PILOT MONTHLY ACTIVITY CLAIM FORM

(Continuity of care for patients assessed during MASS Pilot)

Contractor Number: ____________ Name of Pharmacy: ____________________________

Pharmacy Stamp: ____________________________

MONTH: ____________ YEAR: ____________

PATIENT ID Health & Care Number	Medicines List Accuracy check completed (£40 per patient)		Personalised MASS solution supplied	
	Completed Yes/No	Date	MCA/MDS Yes/No	Medicines Reminder Card Yes/No

I/we declare to the best of my/our belief the information on this form is correct. An audit trail is available at the Pharmacy for inspection by the HSCB's authorised officers or officers acting on its behalf for payment by BSO and pilot evaluation.

Pharmacist Signature ______________________________________ Date: ____________

Please PRINT NAME ______________________________________

Please return completed forms for payment to your local HSCB office each month:

Deaglan Stanton, HSCB (South Eastern) Directorate of Integrated Care 12-22 Linenhall Street Belfast BT2 8BS

Edith McMullan HSCB (Northern) Directorate of Integrated Care County Hall 182 Galgorm Road Ballymena BT42 1QB

For HSCB office use only. Cost Centre: J9FP05 Expense Code: 194B4217

Signature for authorisation of payment ……………………………………Date………………..