PATIENT'S HEALTH NUMBER

PATIENT'S NAME FIRST & SECOND

SEX | Y.O.B. | SURNAME

DETAILS OF COMPOUNDS / OSTOMY SUPPLIES ETC.

PHARMACY NO. | CLAIM NO. 031151

NAME OF PHARMACY

PRESCRIBING DOCTOR | INITIALS / SURNAME

DATE PRESCRIPTION FILLED
DAY MO. YR.

DOCTOR NUMBER

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHARMACARE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

PRESCRIPTION NO.	DIN	O/R	REFILLS AUTH	QUANTITY	DAYS SUPPLY	DRUG COST	FEE	MARK UP	AMOUNT CHARGED	CO - PAY	AMOUNT APPROVED

I CERTIFY THAT THE ABOVE PRESCRIPTION(S) IS FOR THE SOLE USE OF THE PATIENT NAMED ABOVE WHO IS ELIGIBLE FOR BENEFITS UNDER THE M.S.I. PHARMACARE PROGRAM.

X _____

I CERTIFY THIS TO BE A TRUE STATEMENT OF PRESCRIPTION(S) DISPENSED FOR THE PATIENT NAMED ABOVE.

_____

PHARMACIST COPY