



NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1



REQUEST FOR CREDIT INJECTABLE MEDICATION AND OSTOMY SUPPLIES

PHARMACY NAME: _____ PROVIDER NUMBER: _____

CONTACT PERSON: _____

PATIENT NAME: _____

HEALTH CARD NUMBER: _____

PRODUCT NAME: _____ DIN: _____

DATE PRODUCT WAS DISPENSED: _____ DATE OF REVERSAL: _____
(ATTACH COPY OF ORIGINAL PRESCRIPTION)

DATE PRODUCT WAS PURCHASED: _____ MANUFACTURER: _____
(ATTACH COPY OF INVOICE)

LOT NUMBER: _____ EXPIRY DATE: _____

TOTAL AMOUNT CLAIMED: \$ _____

I CERTIFY THAT THE ABOVE PRESCRIPTION WAS FOR THE SOLE USE OF THE PATIENT NAMED ABOVE WHO IS ELIGIBLE FOR BENEFITS UNDER THE NOVA SCOTIA PHARMACARE PROGRAM. I CERTIFY THAT ALL REASONABLE ATTEMPTS HAVE BEEN MADE TO RETURN THIS PRODUCT TO THE POINT OF PURCHASE AND WERE UNSUCCESSFUL.

X

- PLEASE ATTACH:
- A COPY OF THE ORIGINAL PRESCRIPTION
 - A COPY OF THE INVOICE WITH DATE OF PURCHASE AND AAC

Please be advised that the only claims considered are those that cannot be returned to the point of purchase for credit. Requests for reimbursement will only be considered if submitted within six months of the date of service.

Mail to: Nova Scotia Pharmacare Programs
PO Box 500
Halifax, NS B3J 2S1

Or Fax: (902)468-9402