PHARMAC
TE PĀTAKA WHAIORANGA

GEMFIBROZIL DISCONTINUATION: INVOICE FOR REIMBURSEMENT OF WAIVED PATIENT CO-PAYMENT FEES.

Date (dd-mm-yy)

__ __ - __ __ - __ __

Phone Number

Practice Name

Practice Address

GST

__ __ __ - __ __ __ - __ __ __

Bank Account Name

Bank Account Number

__ __ - __ __ __ __ - __ __ __ __ __ __ - __ __

Please provide a bank deposit slip, or a screenshot showing name of supplier/ provider and the bank account number

Patient NHI

Value of co-payment fee waived

Consultation Date (dd-mm-yy)

__ __ - __ __ - __ __

Total amount (incl GST):

By signing below, you verify that:

1. The patient has been prescribed gemfibrozil in the last 6 months
2. The patient has returned for transition from gemfibrozil to alternative agent prior to 31 Dec 2020

Name

Designation

Signed

Submit completed invoice and patient details form to PHARMAC via:

E-mail: enquiry@pharmac.govt.nz

Fax: 04 460 4995

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PATIENT DETAILS FORM

Patient NHI

Consultation Date (dd-mm-yy)

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

Value of co-payment fee waived

Total amount (incl GST):

(Additional pages can be completed if required).