Appendix 2

**Monthly Payment Proforma: Chlamydia Treatment**

Agreement by Lincolnshire Face Facts Chlamydia Screening Programme (NHS Lincolnshire) to pay the Pharmacy

£10.00 per Chlamydia treatment plus cost of treatment at drug tariff rate

**Pharmacy details (payee):**

Pharmacy Name ……………………………….

Address ………………………………

………………………………

………………………………

Postcode ………………………………

PPA Number ………………………………

Site code ………………………………

**Total number of index patient treated Month:**

**Total number of partners treated**

**COMMENTS: continue on separate sheet if necessary**

“All information submitted in this return is true and accurate to the best of my knowledge and belief. I understand that any inaccurate information submitted may result in further investigation to all other returns submitted, the withholding of future payments and possible termination of my contract.”

Signature……………………………… Name (please print)…………………......... Date………………..

**Return to: Dave Varley, Primary Care Support Officer, Orchard House, Greylees, Sleaford, NG34 8PP**

***For Chlamydia Screening Office/finance use only:***

Invoice number: Cost Centre & expense code:

Treatment cost: Total cost to pay:

Budget holder

Signature…………………………….. Name (please print)……………………… Date……………..