PHARMAC
TE PĀTAKA WHAIORANGA

VIGABATRIN (SABRIL): INVOICE FOR REIMBURSEMENT OF WAIVED PATIENT CO-PAYMENT FEES.

Date (dd-mm-yy)

D D – M M – Y Y

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

By signing below, you verify that:

The patient has been prescribed prescribed vigabatrin (Sabril) 500 mg tablets and presented to get a new prescription for vigabatrin (Sabril) sachets due to this supply issue

Name

Designation

Signed

Submit completed invoice and patient details form to Pharmac via:
E-mail: enquiry@pharmac.govt.nz

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PATIENT DETAILS FORM –

Prescriber appointment

Patient NHI

Consultation Date (dd-mm-yy)

D D – M M – Y Y

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

D D – M M – Y Y

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

D D – M M – Y Y

Value of co-payment fee waived

Patient NHI

Consultation Date (dd-mm-yy)

D D – M M – Y Y

Value of co-payment fee waived

Total amount (incl GST):

(Additional pages can be completed if required).