Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Feidhmeannacht na Seirbhíse Sláinte, Seirbhís Aisíocaíochta Cúraim Phríomhúil
Bealach amach 5 an M50, An Bóthar Thuaidh, Fionnghlas
Baile Átha Cliath 11, D11 XKF3
Guthán: (01) 864 7100 Facs: (01) 834 3589

Health Service Executive, Primary Care Reimbursement Service
Exit 5, M50, North Road, Finglas, Dublin 11, D11 XKF3
Tel: (01) 864 7100 Fax: (01) 834 3589

4th September 2017

Circular 037/17

Dear Pharmacist,

The Health Service Executive, as the competent institution in Ireland for the provision of health services under EU regulations 883/04 and 987/09, is required to recoup the costs of the provision of health services to EHIC holders, through the submission of detailed accounts to the relevant EU/EEA state.

To assist contractors in capturing the required information about the client at the point of service provision and to enable the HSE to prepare accounts a new EU Prescription Form (appendix 1) has been released in triplicate format. The top copy is the original prescription form for submission to the HSE upon dispensing in order to claim payment, the second copy should be retained by you for your records and the third copy is retained by the GP for record purposes.

The existing arrangements for claim submission remain in place. New EU Prescription Forms should continue to be submitted as ‘EEA Claims’ on existing claim certificate and summary of claims form.

We very much appreciate your continued co-operation.

Yours faithfully,

Anne Marie Hoey

Anne Marie Hoey
Primary Care Reimbursement & Eligibility

EU PRESCRIPTION FORM

PATIENT DETAILS

NAME:

EHIC NO.

VALID TO: (date)

ADDRESS:

SERIAL NO.

PHARMACY SEQUENCE NO.

PHARMACY STAMP AND COMPUTER NUMBER

This column is for official use only

DOCTOR NO.

DR'S NAME

ADDRESS

MEDICAL COUNCIL REG NO.

Patient Signature

Received by: ....

If not patient, please indicate relationship..........

DATE PRESCRIBED	Precise strength, quantity and dosage must be stated	Age if under 12 years	Years	Mths

NP	PHARMACIST MUST COMPLETE THIS PART
	Month Dispensed

	DRUG CODE	QTY. SUPPLIED

EU

DOCTOR'S SIGNATURE

GMS060 - Part 1

EU PRESCRIPTION FORM
PHARMACY COPY

PATIENT DETAILS

NAME:

EHIC NO.

VALID TO: (date)

ADDRESS:

SERIAL NO.

PHARMACY SEQUENCE NO.

PHARMACY STAMP AND COMPUTER NUMBER

This column is for official use only

DOCTOR NO.

DR'S NAME

ADDRESS

MEDICAL COUNCIL REG NO.

Patient Signature

Received by: ...

If not patient, please indicate relationship...

DATE PRESCRIBED	Precise strength, quantity and dosage must be stated	Age if under 12 years	Years	Mths

NP	PHARMACIST MUST COMPLETE THIS PART	
	Month Dispensed	

	DRUG CODE	QTY. SUPPLIED

GMS060 - Part 2

DOCTOR'S SIGNATURE

EU PRESCRIPTION FORM
GP COPY

PATIENT DETAILS

NAME:

EHIC NO.

VALID TO: (date)

ADDRESS:

SERIAL NO.

PHARMACY SEQUENCE NO.

PHARMACY STAMP AND COMPUTER NUMBER

This column is for official use only

DOCTOR NO.

DR'S NAME

ADDRESS

MEDICAL COUNCIL REG NO.

Patient Signature

Received by: ....

If not patient, please indicate relationship..............................

DATE PRESCRIBED	Precise strength, quantity and dosage must be stated	Age if under 12 years	Years	Mths

NP	PHARMACIST MUST COMPLETE THIS PART	
	Month Dispensed	

	DRUG CODE	QTY. SUPPLIED

GMS060 - Part 3

DOCTOR'S SIGNATURE