GROUP NO.

CLIENT / FAMILY

PRESS FIRMLY - USE PEN

EMPLOYEE / SUBSCRIBER NAME

INITIAL

PHARMACY NAME

STREET ADDRESS

CITY & PROVINCE

PHARMACY PROVIDER NO.

Manual Pharmacy Claim

Please submit second copy to:

MHCSI
201 BROWNLOW AVE.
UNIT 20
DARTMOUTH, NOVA SCOTIA B3B 1W2

☐ PLEASE CHECK IF THIS IS A CREDIT (REVERSAL)

PATIENT'S FIRST NAME	PATIENT CODE	BIRTHDATE Y / M / D	DRUG IDENTIFICATION NO. (DIN)	QUANTITY	DAYS SUPPLY	PRESCRIPTION NUMBER	DATE DISPENSED Y / M / D	GROSS CLAIM AMOUNT	PREV PAID (COB)	CO-PAY	PLAN PAYS

PHARMACIST SIGNATURE (AND PRINT NAME IN FULL)

GROUP NO.

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