Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Prescription Charge Refund Claim Form Form PC1

Information and Data Protection Notice

1. From 1st October 2010, people with Medical Cards pay a charge for medicines and other items that they get on prescription from pharmacies. From 1st December 2013 the total charge your family must pay is subject to a monthly limit of €25.00.
2. **A family group is you, your spouse / partner, and your children under 21 who are in full time education.**
3. Where your family group uses a single pharmacy each month and where that pharmacy can identify all your family members then you should not pay more than the monthly limit.
4. If your family has visited more than one pharmacy and has paid more than the monthly limit then the HSE will **automatically issue refunds** based on the information received from pharmacies.
5. If you consider that you have not received the refund due to you, please apply to the HSE on this claim form.
6. **Data Protection Notice:** Personal data collected by the HSE is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

Part 1: Applicant's Details – Please use BLOCK CAPITALS

Medical Card Number:			Address
PPS Number:			1:
First Name:			2:
Surname:			3:
Daytime Phone:			Town:
E-mail address:			County:

Part 2: Refund Claim Details for One Month

Insert the Month where Prescription Charges Were Overpaid, *e.g. Jan 2014*:

On each line as required, insert the medical card number of each family member who paid prescription charges in the month concerned. Insert the number of the pharmacy (available from the pharmacy) where those charges were paid and the total charges paid by that person. See the example in the notes provided on the back of this form.

	Medical Card Number	Pharmacy Number	Prescription Charge Paid
1.			€
2.			€
3.			€
4.			€
5.			€
6.			€
7.			€
8.			€

Part 3: Declaration

I declare that all the details stated on this claim form are complete, true and correct. I also declare that I/my family has paid all the prescription charges detailed and that this is the only claim submitted by me/my family in respect of these charges.

Signature:		Dated:	d d m m y y y y

Frequently Asked Questions

When Should I Use This Form:

1. The HSE will issue refunds **automatically** to you based on the information received from your pharmacy.
2. If you consider that you have not received the refund due to you, please apply to the HSE on this claim form.
3. This should only happen if your family group uses more than a single pharmacy in the month or if your pharmacy cannot identify all of your family members.
4. You may submit more than one claim form at a time.

Can I Avoid Refund Claiming?

Yes. In the normal course of events the HSE will issue refunds **automatically** to you. Refunds can be avoided altogether if your family uses a single pharmacy in the month and if that pharmacy can identify all of your family members. In that case you should not pay more than the monthly limit.

Where Can I Get a Copy of this Claim Form?

This refund claim form is available on www.hse.ie/medicalcard or at your Local Health Office or by calling 1890-252-919

Where Do I Send Refund Claims?

Refund claims should be addressed and sent to:
Prescription Charge Refund Claims,
PO Box **11950**
Finglas,
Dublin 11.

Where Can I Get Assistance with this Form?

Please call 1890-252-919 and we will help you.

Notes: How To Fill This Prescription Charge Refund Claim Form

Part 1: Applicants Details:

1. Please carefully insert the medical card number and also the PPS number of the applicant.
2. If your address has changed since you got your medical card then please enclose a copy of a recent utility bill with your claim to verify this address.
3. Please supply daytime contact details in the event we need to contact you regarding your claim.

Part 2: Refund Claim Details:

1. Fill this part as per this example.

	Medical Card Number								Pharmacy Number (*)					Prescription Charge Paid
1.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*A*	*1*	*2*	*3*	*4*	*5*	*€7.50*
2.	*5*	*6*	*5*	*3*	*4*	*5*	*6*	*A*	*9*	*7*	*8*	*6*	*5*	*€8.50*

(*) Please ask the pharmacy which dispensed your prescription for this number.

Part 3: Declaration:

Please read this declaration carefully and when you are satisfied that the details on the form are correct, sign and date it accordingly.