Government of Saskatchewan
Ministry of Health

Pharmacy Claim

Drug Plan and Extended Benefits Branch
3475 Albert Street Regina, SK S4S 6X6
FAX 306-787-8679 DPEB@health.gov.sk.ca

Pharmacy No.	Claim No.
P	

Dispensing Date ▶	Day	Month	Year

Pharmacy Phone No.

Pharmacy Name _____

Address _____

_____

Patient Name and Health Services Number	Health Provider		Pharmacist	
	Org ID	Health Provider Identifier	Org ID	Pharmacist ID

- 1 -

Prescription No.	N/S	Quantity	D.I.N	Unit Drug Cost	Dispensing Fee	Compounding Fee	Discount %	Total Rx Cost	Patient Paid
				.	.	.		.	.

Mark-up %	T1	T2	T3	Days Supply	Methadone MG per day	Compound Name (1)	F 1	F 2	F 3
					.				

- 2 -

Prescription No.	N/S	Quantity	D.I.N	Unit Drug Cost	Dispensing Fee	Compounding Fee	Discount %	Total Rx Cost	Patient Paid
				.	.	.		.	.

Mark-up %	T1	T2	T3	Days Supply	Methadone MG per day	Compound Name (1)	F 1	F 2	F 3
					.				

- 3 -

Prescription No.	N/S	Quantity	D.I.N	Unit Drug Cost	Dispensing Fee	Compounding Fee	Discount %	Total Rx Cost	Patient Paid
				.	.	.		.	.

Mark-up %	T1	T2	T3	Days Supply	Methadone MG per day	Compound Name (1)	F 1	F 2	F 3
					.				

Reason for Submission _____

_____

_____

Date_____ Signature _____

(1) only required for extemporaneous preparations. **(F1)** Claim also submitted to another paying agency **Y** ☐ **N** ☐. **(F2)** Mask Rx at patients request **Y** ☐. **(F3)** Adjudication Flag **Y** ☐ **N** ☐.