Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Drugs Payment Scheme
Refund Claim Form DPSR1

Information and Data Protection Notice

1. From 1st March 2011, refund claims from a person or family group registered under the Drugs Payment Scheme (DPS) who opt to use more than one pharmacy will have their refund claims processed centrally through the Primary Care Reimbursement Service (PCRS).
2. **A family group is you, your spouse / partner, and your children under 18 and/or dependants under 23 years who are in full time education.**
3. **You must be registered under the Drugs Payment Scheme to claim a refund. DPS Application forms are available from your Local Health Office or online at *www.drugspayment.ie***
4. Where a family group uses a single pharmacy each month they should not pay more than the monthly DPS co-payment amount.
5. ***If your family has visited more than one pharmacy and has paid more than the monthly co-payment, the HSE will process your claim based on the information you provide from your pharmacy. Refunds will be paid at the approved HSE Drugs Payment Scheme (DPS) prices as reimbursed to pharmacies by the HSE. Confirmation receipt of items dispensed from your pharmacies must be attached to your claim. The full list of reimbursable items is available online at www.hse.ie/eng/staff/pcrs/items***
6. Claims which arise from using a community pharmacy and from using an approved service provided by a supplier other than a community pharmacy e.g. CPAP/Oxygen, will also be processed centrally through the PCRS. These claims must be accompanied by a confirmation receipt of co-payment to a community pharmacy where such applies in the calendar month and a copy of the supplier's invoice.
7. If you consider that you are eligible for a refund, please apply to the HSE on this claim form.
8. **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

Drugs Payment Scheme Number:													Address
PPS Number:													1:
First Name:													2:
Surname:													3:
Daytime/Mobile Ph No:													Town:
E-mail address:													County:

Part 2: Refund Claim Details for One Month

Insert the Month where the DPS amount paid by your family was in excess of the co-payment amount, *e.g. Mar 2011*:	
Is this claim in respect of the direct supply of a service/item other than a service/item from a community pharmacy e.g. CPAP/Oxygen? If 'Yes' insert supplier's name:	Please tick appropriate box: Yes ☐ No ☐

On each line as required, insert the DPS number of each family member who paid in the month concerned. Insert the number of the pharmacy (available from the pharmacy), date dispensed, and confirm receipt attached. See the example in the notes provided on the back of this form.

	DPS Card Number										Pharmacy Number					Date Dispensed	Confirmation receipt of items dispensed is attached (Yes)
1.																	
2.																	
3.																	
4.																	
5.																	

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 for all of the drugs/medicines/service set out in this claim and that this is the only DPS Refund claim submitted by me/my family in respect of this month. I give consent to the HSE to make appropriate enquiries with those involved in the prescription and supply of these medicines/service for the purpose of considering my application.

Notice: A person who knowingly makes a false statement, conceals any material fact or produces false documents is liable to a fine up to €127 or to imprisonment for up to three months, or both a fine and imprisonment. (Section 75, Health Act, 1970).

Signature:	Dated:	D	D	M	M	Y	Y	Y	Y

Frequently Asked Questions

When Should I Use This Form?

1. If you or your family has opted to use more than one pharmacy and have paid in excess of the Drugs Payment Scheme monthly co-payment amount for the month. Note: In this circumstance your claim should be labelled **'DPS Refunds – Community Pharmacy**'.
2. If you or your family has received items from your community pharmacy and from an approved service provided by a supplier other than a community pharmacy e.g. CPAP/Oxygen. Note: In this circumstance your claim should be accompanied by a confirmation receipt of co-payment to a community pharmacy and a copy of the supplier's invoice and labelled **'DPS Refunds – All Services'**.

Do I have to be registered under the Drugs Payment Scheme to claim a refund?

Yes, patients must be registered under the Drugs Payment Scheme. Application forms are available at your Local Health Office or on ***www.drugspayment.ie***.

Can I Avoid Refund Claiming?

Refunds can be avoided altogether if your family uses a single pharmacy in the month. In that case you should not pay more than the monthly co-payment amount.

Where Can I Get a Copy of this Claim Form?

This form is available on ***www.drugspayment.ie*** or at your Local Health Office or by calling 0818 224478.

Where Do I Send Refund Claims?

Refund claims should be sent to:
'DPS Refunds – Community Pharmacy' or 'DPS Refunds – All Services',
PO Box **12012**, Dublin 11.
Alternatively scan your full application to pcrs.dpsr@hse.ie

Where Can I Get Assistance with this Form?

At your Local Health Office or by calling 0818 224478.

Notes: How To Fill This Drugs Payment Scheme Refund Claim Form

Part 1: Applicants Details:

1. Please carefully insert the DPS number and the PPS number.
2. If your address has changed since you got your Drugs Payment Scheme card then please enclose a copy of a recent utility bill with your claim to verify your new address.
3. Please supply daytime/mobile number in the event that we need to contact you regarding your claim.

Part 2: Refund Claim Details:

1. Complete this part as per this example.

	DPS Number										Pharmacy No.*					Date	Confirmation receipt of items dispensed is attached (Yes)
1.	0	1	2	3	4	5	6	W	A		1	2	3	4	5	DD MM YY	YES
2.	5	6	5	3	4	5	6	W	B		9	7	8	6	5	DD MM YY	YES

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

Part 3: Declaration: Please read this declaration carefully and when you are satisfied that the details on the claim form are correct, sign and date it accordingly.