

GOS 1 Application for an NHS funded sight test

Please complete this form using black ink and in block capitals

Part 1 Patient's details

* delete as appropriate

Mr/Mrs/ Surname: _____ Previous surname: _____
 (If changed within the past 12 months)
 Miss/Ms*: _____
 First names: _____ Date of birth: / /
 Address: _____

Postcode: _____

if known

Date of last sight test: / / NHS no#: _____ N.I.no#: _____

I am 60 or over I am under 16[†]

I am a full time student aged 16, 17 or 18[†] and attend:

Tick all boxes in Part 1 that apply to you

School/College/University*: _____

Address: _____

Postcode: _____

[†]You may be entitled to an optical voucher if you are in one of these groups. Ask the person who tests your sight.

I/my* partner receive(s):

Income Support[†]

Income based Jobseekers Allowance[†]

Income-related Employment and Support Allowance[†]

Pension Credit guarantee credit[†]

Tax Credit and I am/we are named on a valid NHS Tax Credit Exemption Certificate[†]

Person getting the benefit/credit* if not the patient: _____ N.I.no#: _____

Name: _____ Date of birth: / /

I am named on a valid HC2 certificate. Number: _____

I am registered blind/partially sighted* with the Local Authority below

I suffer from diabetes/glaucoma* - my GP's details are below

I am considered to be at risk of glaucoma by an ophthalmologist at the hospital below

I am 40 or over and am the parent/brother/sister/child* of a person who has or had glaucoma

I am a prisoner on leave from the prison detailed below:

I have been prescribed complex lenses under the NHS optical voucher scheme



GP/Local Authority/hospital/prison*: _____

Address: _____

Postcode: _____

Part 2 Patient's declaration

This is my application for an NHS funded sight test. I declare that the information given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and/or civil proceedings. I confirm I am entitled to an NHS funded sight test and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud.

I agree to repay the cost of the sight test if I am later found not to be entitled to it.

** If you are under 16 or incapable of signing, your parent, carer or other person responsible for you should sign and give their name and address.

I am the patient patient's parent, carer or guardian.

Signature**: _____ Date: / /

Name: (in block capitals)

Address: (if different from above)

Postcode: _____

Part 3 Performer's declaration

I have tested the sight of the person named on this form on

Date: / /

- The patient was referred to their GP or Ophthalmic hospital
- A statement was issued showing no prescription was required
- An unchanged prescription was issued
- A new or changed prescription was issued
- A voucher was issued:

First voucher type: Supplements: Complex Prism Tint
 Second voucher type: Supplements: Complex Prism Tint

†If the sight test has been conducted by the contractor only one signature is required at the bottom of this form

To be completed by the Performer who has conducted the sight test†

Performer's signature:

Performer's name:
(in block capitals)

Performers list number:

Date: / /

CLAIM I claim the current NHS sight test fee.

In the case of a re-test at less than the standard interval, please specify the appropriate code.

Practice address where sight test took place:
(in capitals/stamp)

Address *(if different)* where payment should be sent:
(in capitals/stamp)

DECLARATION

I claim the payment shown above under the General Ophthalmic Services Contracts Regulations. I confirm that the information given on this form is correct and complete and that this is the original form as signed by the respective patient, or other person as appropriate. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and/or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of this claim and in relation to the prevention and detection of fraud.

To be completed by the contractor or authorised signatory

Signature:	Contractor's name and address: <i>(in capitals/stamp)</i>
Name: <i>(in block capitals):</i>	
Date: / /	
Contractor number <i>(where issued):</i>	
Performers list number <i>(if appropriate):</i>	