

GOS 5 Help with the cost of a private sight test

If you (or your partner) are named on a valid HC3 certificate for partial help with health costs, you may be able to get help with the cost of a private sight test. For more information see leaflet HC11 - "Help with Health Costs", which is available from the following website: www.dh.gov.uk or by calling 08701 555 455. If you think you might be entitled to help with the cost of your glasses, ask when you have your 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#:					
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Reason for patient's entitlement to vouchers

I/my partner are named on a valid HC3 certificate, number: _____
 - showing (at **box A**) that I have to pay up to £ _____ for a private sight test.

I will pay up to the amount above (plus any difference between the NHS sight test fee and the cost of my sight test) provided my sight test cost more than the NHS sight test.

Note: The person who tests your sight can tell you the NHS sight test fee. This is also in leaflet HC12 "NHS charges and optical voucher values". This is available from the following website: www.dh.gov.uk or from NHS Forms c/o 3M SPSL, Gorse Street, Chadderton, Oldham, OL9 9QH or by telephoning 0845 610 1112.

I cannot attend a practice unaccompanied for a sight test because:

Part 2 Patient's declaration

This is my application for help with the cost of a private 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 proper entitlement to help with the cost of a private 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 amount granted if I am later found not to be entitled to it.

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

*** 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*

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

This patient was the:

- 1st patient at the address
- 2nd patient at the address
- 3rd or subsequent patient at the address

**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 for a sight test:

Lower of private charge or NHS sight test fee	£	(1)
Lower of the private charge or NHS domiciliary visit fee <i>(where appropriate)</i>	£	(2)
Maximum claimable in respect of sight test <i>(sum of 1+2)</i>	£	(3)
Patient's contribution as shown by box A of HC3	£	(4)
Total claim in respect of sight test <i>(3 minus 4)</i>	£	

Address where sight test took place <i>(in capitals/stamp)</i>	Address of contractor who provided sight test <i>(in capitals/stamp)</i>	Address (if different) where payment should be sent <i>(in capitals/stamp)</i>

DECLARATION

I claim the payment shown above under the NHS (Optical Charges and Payments) Regulations 1997. I declare 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>	