

GOS 6 Application for a mobile 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/ Miss/Ms*: Surname: Previous surname:
 (If changed within the past 12 months)

First names: Date of birth: / /

Address:

Postcode:

if known

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

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

I am 60 or over I am under 16[†] I am a full time student aged 16, 17 or 18[†] and attend:

School/College/University*:
 Address:
 Postcode:

Tick all boxes in Part 1 that apply to you.

[†]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[†] Pension Credit guarantee credit[†]
 Income based Jobseekers Allowance[†] Tax Credit and I am / we are named on, a valid NHS Tax Credit Exemption Certificate[†]
 Income-related Employment and Support Allowance

Person getting the benefit/credit* if not the patient: NI 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 have been prescribed complex lenses under the NHS optical voucher scheme



GP/Local Authority/hospital*:
 Address:
 Postcode:

Part 2 Patient's declaration

This is my application for a mobile 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 a mobile 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

I have made a domiciliary visit to conduct this sight test to one patient at the address in Part 1

I have made a domiciliary visit to several patients at the address in Part 1

This patient was the:

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

The patient was referred to their GP or Ophthalmic hospital

A statement was issued and 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)* Date:

Performers List number:

CLAIM

I claim:

the current NHS sight test fee
 the domiciliary fee for:
 1st patient at the address
 2nd patient at the address
 3rd or subsequent patient at the address
 Total claim for sight test

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

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>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

DECLARATION

I claim the payment shown above under the General Ophthalmic Services Contracts Regulations. 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: <input type="text"/>	Contractor's name and address: <i>(in capitals/stamp)</i>
Name: <i>(in block capitals):</i>	<input type="text"/>
Date: <input type="text" value="/"/> <input type="text" value="/"/> <input type="text" value=""/>	<input type="text"/>
Contractor number <i>(where issued):</i>	<input type="text"/>
Performers list number <i>(if appropriate):</i>	<input type="text"/>