el el multiple cuciun i terra el with health code, you may de able lo gel heo with the cod di a private agrit nich la available al wavenna ukhealthcoats. Il you traini you migh be entited to Paruar nor which is avail

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rtificate numbe

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(G) your pather) are hamed on a vald HC3 certificate for partial heap with Log your pather) are hamed on a vald HC3 certificate for partial heap with the cost of your glasses, set when you have your sight test the cost of your glasses, set when you have your sight test takes complete this form using black thit and in BLOCK CAPTILIS.

Date of birth Date of last sight test:

ELIGIBILITY

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### **GOS Paper Forms**

How to Avoid **Unnecessary Rejections** Guide

22nd March 2022 – V1.0



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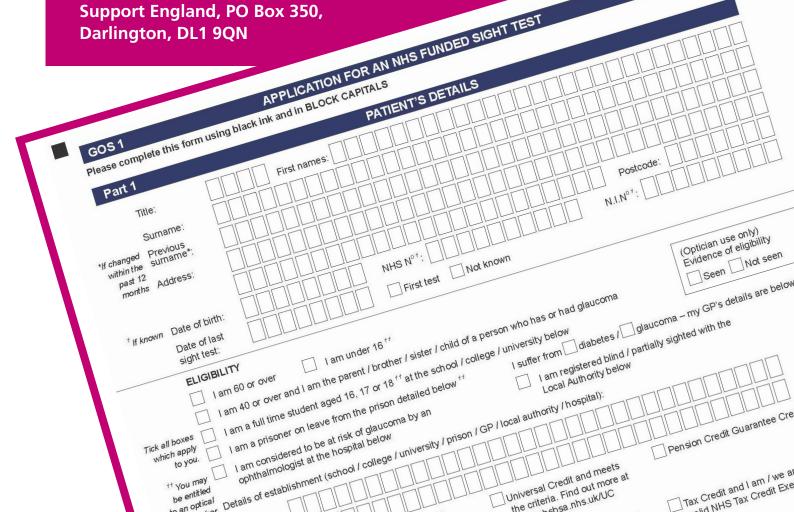
06/20

NHS England and NHS Improvement launched new style paper GOS forms on the 1st February 2021. You can order the paper GOS forms (GOS1, 3, 4, 5 and 6) from PCSE Online and the forms are delivered to the practice.

This guide has been created to give you an insight into how these paper forms need to be completed to avoid unnecessary rejections.

Before continuing, please remember the following:

- The appropriate form must be completed by the optician during the patient's visit for their sight test, optical repair or a claim for new glasses.
- Forms must be completed correctly to ensure they are not rejected. Use this guide to avoid any necessary rejections. You will find our Top 10 Rejection Reasons on the next page.
- Once forms are completed, they need to be posted, with the batch header, to Primary Care Support England, PO Box 350, Darlington, DL1 9QN





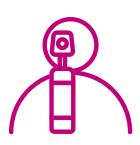
### TOP 10 THINGS TO REMEMBER TO AVOID UNECESSARY REJECTIONS



The second voucher type is optional and should only be provided if a first voucher type has been provided. Either provide a second voucher code or select the complex lens option. Valid second voucher type codes are: A, B, C, D. (GOS 1, 5 & 6)



Please ensure the signatory's address is provided. (All GOS claims)



If a near add has not been prescribed only a distance pair can be supplied. (GOS 3 & 4)

There is an error in the left distance sphere field. Please ensure the following:1) A numerical value between 0 to 99.75 in 0.25 increments is provided.2) If a distance SPH has a value greater than 0.00, then a +/- sign is provided 3) the left distance sphere field is completed.

(GOS 3 & 4)

An NHS eligibility option is selected that requires the NHS eligibility benefit recipient of either 'I' or 'My Partner' to be selected.

(All GOS claims)



### TOP 10 THINGS TO REMEMBER TO AVOID UNECESSARY REJECTIONS



Please complete the evidence of eligibility box and select either seen or not seen. (All GOS claims)

01-2345 Please ensure the performers list number is provided. (GOS 1,3,5,6)

**JANE SMITH** Please ensure the signatory name under the patient's declaration is provided. (All GOS claims)



Please ensure the patient and supplier's declaration for glasses/ contact lens supplied are consistent with regard to whether it is a distance, near or bifocal/varifocal pair. (GOS 3 & 4)



If contact lenses, or a distance, bifocal or near pair of glasses is supplied, please ensure the voucher supplements value for the first pair is provided.

You will find this in the suppliers declaration – Part 3, sub section 2. (GOS 3)

## **GOS 1 Paper Form**

NDED SIGHT TEST

# Explained



### Tips for Completing Paper GOS 1 forms

- X Complete using black ink.
- X In BLOCK capital letters.
- X Ensure that all the characters you write are centred within the boxes.

NHS England

**Primary Care Support England** 

	mandatory information.
In part 1 of the patients details, you need to enter the patients:	GOS 1         APPLICATION FOR AN NHS FUNDED SIGHT TEST         06/20           Please complete this form using black ink and in BLOCK CAPITALS         06/20         06/20
<ul> <li>✓ Title</li> <li>✓ First Name</li> <li>✓ Surname</li> <li>✓ Previous surname (if applicable)</li> <li>✓ Full address and postcode</li> </ul>	Part 1 PATIENT'S DETAILS
All dates must be entered in the same format of (DDMMYYYY) as an example: <b>31032021</b> If you don't know the exact date of the last sight test, you can enter the year in the last 4 boxes.	withing summer:       1       2       3       5       T       R       E       T       N       A       M       E         past 12       months       Address:       T       O       W       N       E       E       T       N       A       M       E       Postode:       L       S       1       0       A       M       E       Postode:       L       S       1       0       P       A       N
You must declare if you have seen 'Evidence of the patients eligibility' or not. Simply cross 'Seen' or 'Not seen'. One option MUST be crossed.	ELIGIBILITY         I am 60 or over       I am under 16 **         I am 40 or over and I am the parent / brother / sister / child of a person who has or had olaucoma       (Optician use only)         Tick all boxes       I am a full time student aged 16, 17 or 18 ** at the school / college / university below       Seen X Not seen         Which apply       I am a prisoner on leave from the prison detailed below **       I suffer from
You need to place a cross $(X)$ in all of the eligibility boxes that apply to the patient. If applicable to the eligibility category, you need to complete the name and town of the establishment.	too may intervention of the second of t
For eligibility due to benefits, you must cross the correct box to indicate if the patient or their partner/someone they are a dependant of if they are under 20 is the recipient of the benefit. If the benefit recipient is not the patient,	+ teets your sight       I / my partner, implement       Income Support ''       Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC         on if I am under 20, receive(s) or is included in an award of:       Income-based Jobseeker's Allowance ''       Mcome-related Employment and Support Allowance ''       Tax Credit and I am / we are named on a valid NHS Tax Credit Exemption Certificate ''
you must enter the name, NI Number (if known) and DOB of the person receiving the benefit.	Name:         Date of birth:         Date of birth:           I am named on a valid HC2 certificate **         Certificate number: HC2 - 123456789
For HC2 put a cross in this box and enter certificate number. <b>Do not cross</b> I/my partner above.	I have been prescribed complex lenses under the NHS optical voucher scheme <sup>ff</sup> Part 2     PATIENT'S DECLARATION      If you are     Meclare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken against     under 16 or     me including repayment of the NHS sight test fee and payment of a penalty charge. To enable the NHS to check my entitlement, and on the basis     incapable     of NHS England performing tasks in the public interest, my personal data may be disclosed to NHS Business Services Authority, Department     of signing, for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, education providers, HM Prison Service, local     your parent,     authorities, and bodies performing functions on their behalf. I may also be contacted about this form or the test. My claim will be processed by
	carer or PCSE (Capita) and the relevant controller is NHS England. I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy- other person notice/ or by contacting 0300 311 22 33. Where I have provided personal data on behalf of another person, they agree to me doing so, and I will draw their attention
If the person signing is someone other than the patient, then a cross ( <b>X</b> ) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered. A cross ( <b>X</b> ) should be place in the 'same address as patient' box where appropriate.	carer or PCSE (Capita) and the relevant controller is NHS England. I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy- other person notice/ or by contacting 0300 311 22 33. Where I have provided personal data on behalf of another person, they agree to me doing so, and I will

	<ul> <li>Complete using black ink.</li> <li>In BLOCK capital letters.</li> <li>Ensure that all the characters you write are centred within the boxes.</li> <li>Make sure you complete all of the mandatory information.</li> </ul>
A cross should be placed against the patient's ethnic group if they wish to complete this section.	Please choose ONE selection from the list to indicate your ethnic group (optional):         White       Mixed       Asian or Asian British       Black or Black British       Other ethnic groups         British       White and Black       Asian or Asian British       Black or Black British       Other ethnic groups         Inish       White and Black       Asian or Asian British       Black or Black British       Other ethnic groups         Any other       African       Asian or Asian British       Black or Black British       Any other         Any other White       White and Asian       Asian or Asian British       Black or Black British       Any other         background       White and Asian       Asian or Asian British       Black or Black British       Any other         Any other mixed       Any other Asian       background       background       background
You must enter the date the sight test took place in the format DDMMYYY.	Part 3       PERFORMER'S DECLARATION         I have tested the sight of the person and on this form on:       3 1 0 3 2 0 2 1         The patient was referred       A number of the prescription was required         A statement was issued showing no prescription was required       An unchanged prescription was issued
Record an early retest code if applicable. For example: Use code 1, 2 and 6. NOT 1.0, 2.0 and 6.0.	A voucher was issued: Distance/ Bifocal voucher type: A or / Complex Supplements: Prism Tint Reading voucher type: or / Complex Supplements: Prism Tint Ke bottom of this form. Please put a cross in
If the patient is issued a voucher you should insert the appropriate voucher category in these boxes.	To be completed by the Performer who has conducted the sight test Performer's name: FIRSTNAMESURNAME
The performer who has conducted the sight must enter their name and Performer List number which is the GOC number and must be entered in the format 01-99999. There is no longer a prefix or suffix on a PL number. They will also need to sign and date the form here, unless they are a contractor.	+ Performer's signature: Date: 31032021 + DECLARATION I claim the current NHS sight test fee under the NHS (Optical Charges and Payments) Regulations 2013. 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.
If the performer is also the contractor, then a cross should be entered here to indicate this and the form should be signed in the contractor declaration section.	I understand that if I withhold information or provide false or misleading information, disciplinary action have be taken against me and I may be liable to prosecution and or civil proceedings. I understand that my personal data will be processed by PCSE (Capita) to verify this Claim and the relevant controller is NHS England. I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy-notice/, or by contacting 0300 311 22 33. To be completed by the contractor or authorised signatory
This final declaration must be completed by the 'contractor' or 'authorised signatory'. They must include: ✓ Their signature ✓ The date completed	Signature:       Date:       31032021         Name:       FIRSTNAMESURNAME       Date:       31032021         Contractor's name:       PRACTICENAME       Date:       31032021         Organisation number:       A1A1A       A1A1A       Date:       31032021
<ul> <li>✓ Their name</li> <li>✓ The contractor's name (i.e. the practice name)</li> <li>✓ Organisation number (ODS code)</li> </ul>	
Claims cannot be processed without the correct 5 character ODS code. The link below can help you find the right ODS code for your practice: https://odsportal.digital.nhs.uk/ Organisation/Search	



Did you know you can submit GOS claims electronically through PCSE Online? PCSE Online validates the claim in real time preventing any errors or omissions before you submit the claim.

## **GOS 3 Paper Form**

INAS OPTICAL VOUCHER AND PATIENT'S STATEMENT To del your diases fill in dign and date par 2 when your date mention the optical of your diade. San and date par 4 oreeleast To del your diases fill in dign and date par 2 when your date mention the optical of your diade. San and date par 4 oreeleast To del your diases fill in dign and date par 2 when your date mention the optical of your diade. San and date par 4 oreeleast To del your diases fill in dign and date par 2 when your date mention the optical of your diade. San and date par 4 oreeleast To del your diases fill in dign and date par 2 when your date mention the optical of your diade. San and date par 4 oreeleast To del your diases fill in dign and date par 2 when your date when your diade the sam and the DOCK CAPITALS To del your diases fill in dign and date par 2 when your date when your diade part in the optical of your diade. San and the DOCK CAPITALS To del your diases fill in dign and date part 2 when your diade part in the optical of your diade. San and the DOCK CAPITALS To del your diases fill in dign and date part 2 when your diade part in the optical of your diade. San and the DOCK CAPITALS Part 1

# Explained

TUTUT



- Tips for Completing Paper GOS 3 forms
- X Complete using black ink.
- X In BLOCK capital letters.
- X Ensure that all the characters you write are centred within the boxes.
- X Make sure you complete all of the

Primary Care Support England

England

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In part 1 of the patient's details, you	GOS	3			NF	IS C	OPTIC	AL	VOL		R AI		ATIE	NT'	S ST	ATE		T					0	6/20
need to enter the patient's:	To get y	our glasses/conta			i, sign a	and d	ate Pa	rt 2 v	vhen y	ou ord	er the	em fro	m the	optici	an of	your	choic		n and	date	Part	4 over		
<ul> <li>✓ Title</li> <li>✓ First Name</li> </ul>		rm that you have	eceiveo	d them.	Please	con	nplete	this		-				BLOC	CK C/	APITA	ALS							
<ul> <li>✓ Surname</li> <li>✓ Previous surname (if applicable)</li> </ul>	Part				1		_			TIEN									_					
✓ Full address and postcode		Title.	MR		First	nam	es: F	I	RS	Т	Ν	A	ΛE	_										
		Surname:	S U	RN	AM	E																		
		Previous surname*:	1 2	3	S T	R	ΕE	Т	N	A	۸E													
All dates must be entered in the same	past 12 months	Address:	то	WN																				
format of (DDMMYYYY) as an example:			CI	ΤУ														Po	ostcoo	ie: L	. s	1 1	0	ΡΑ
31032021	tir known	Date of birth:	3 1	03	19	8	8	NHS	S № * :								N	I.I.N°⁺	:					
		ELIGIBILITY																			-			
You must declare if you have seen 'Evidence of the patients eligibility'		My name and ad to use the above					l wish	to or	rder gl	asses	cont	act lei	nses a	nd I a	am en	titled								
or not. Simply cross 'Seen' or 'Not		I am under		i today	boodua													$\rightarrow$				use or		
seen'. One option MUST be crossed.	Tick all boxes which apply	X I am a full ti	me stud	lent age	ed 16, 1	7 or	18 at t	he so	hool /	colleg	e / un	iversi	y belo	w								of elig	-	n
You need to place a cross (X) in all of the	to you. These	I am a priso	ner on l	eave fr	om the	priso	n detai	iled b	elow										L					
eligibility boxes that apply to the patient.		Details of establis	shment	(school	/ colleg	ge / u	niversi	ty / p	rison)															
If applicable to the eligibility category, you need to complete the name and	order your glasses or	Name: E	S T	AE	LI	5	ΗN	۱E	ΝT		NA	ΜB												
town of the establishment.	contact lenses	Town:	0 1	/ N	NA	M	E																	
For eligibility due to benefits, you must	$\rightarrow$	XI / _ my par			ncome \$	Supp	ort		[	Univ							Pen	sion (	Credit	Guara	antee	Credi	t	
cross the correct box to indicate if the		or person I am de on if I am under 3	20,										d out r hs.uk/		at									
patient or their partner/someone they are a dependant of if they are under 20	+	receive(s) or is in in an award of:	ncluded						, г	Income-related Employment     Tax Credit and I am / we are named on a														
is the recipient of the benefit.					icome-l Allowan		a jobs	ееке	rs				owand		nı	L						re nar mptior		n a ificate
If the benefit recipient is not the patient, you must enter the name, NI Number (if		Person getting the benefit / credit if not the patient:																						
known) and DOB of the person receiving the benefit.		Name:																				]		
		N.I. Nº *:						Di	ate of	birth:						]						_		
For HC2 put a cross in this box and enter certificate number. <b>Do not cross</b>	$\rightarrow$	I am named on a	valid:	Пнс2	or	HC3	 certific:			∟ Certifio	ate n	umbe	r: HC	-										
I/my partner above.			_		) (box E									d by:	£		1							
		I have been	prescri	bed co	nplex le	enses	s unde	r the	NHS	optical	vouch	ner sc	heme	-										
	Part	2						P		NT'S	DE		RATI	ON										
		I declare that the	informa	ation I h	ave giv	en o	n this fe								d that	t if it is	s not,	appro	priate	e actio	n ma	y be ta	aken	
		against me includi and on the basis																						
	of signing,	Department for V local authorities,	Vork and	d Pensi	ons, HN	/I Re	venue	& Cu	istoms	, NHS	Digita	al, NH	S Cou	nter F	raud	Autho	ority, e	educa	tion p	rovide	rs, H	M Pris	on Se	ervice,
	carer or	PCSE (Capita) a	nd the r	elevan	contro	, Iler is	NHS	Enala	and. I	can fin	d out	more	about	mv ri	ahts a	at: htt	w//:za	ww.er	nalano	i.nhs.u	uk/co	ntact-ı	us/priv	acv-
	responsible	notice/, or by cor draw this notice t	tacting o their a	u300 3 attentio	11 ZZ 3 1.	3. VV	nere i i	nave	provid	iea pei	sona	data	on be	nair o	r anoi	iner p	erson	, they	agre	e to m	e ao	ng so,	and I	WIII
If the person signing is someone other than the patient, then a cross ( <b>X</b> ) must	for you should sign	I am the pati	ent 🗌	patient	s paren	nt X	patier	nťs c	arer o	guard	ian									sa	ame a	addres	s as p	atient
be placed against 'patients parent' or	and give their name		(	-																				
'patients carer or guardian' box' and the name of the signatory entered.	and address	$\longrightarrow$		منر	n																			
A cross ( $\boldsymbol{x}$ ) should be place in the		Signature**:		0														Date:		3 1	. 0	3 2	0	2 1
'same address as patient' box where appropriate.			C T	D C			44 5		<u> </u>			44 5												
		Name:			TN		ME		5 0	RN		ME												
		Address:	AD	DR	ΕS	S		ļļ	_				<u> </u>											
																		P	ostco	de: l	_ S	1 1	0	PA
							Vou	ucher	code							Autho	orisati	on co	de:					
	7676	1 -															Ρ-							



		×	Complete using	black ink.	
Tips for C	omnlat		In BLOCK capita	l letters.	NHS
Paper GO			Ensure that all t are centred wit	the characters you wr hin the boxes.	
		×	Make sure you mandatory info	complete all of the rmation.	Primary Care Support England
prism cimal place and use in, ot, up,	PRESCRIPTION +/- Sph fo to R + 1.50 y the G + ADD 1.75	일디디다 다다 디란니		+/- Sph +/- Cyl 0.00 - 1.2 pp 1.75	Axis Prism Base L 85
for the other and Discourse at	your test Distance/ Bifocal v Reading voucher To be completed Performer's name:	voucher type: E or / Com type: or / Com by the Performer who has con I R S T N A M E 1 - 9 9 9 9 9	plex Supplements:	rism Tint	otion: 3 1 0 3 2 0 2 1
Enter the relevant categories for the voucher types being prescribed and cross Prism or Tint if supplements being applied.	Performer's signature:	Sign	SUPPLIER'S DECL	D	ate: 31032021
GOS 3 must enter their name and Performer List number which is the GOC number and must be entered in the format 01-99999. There is no longer a prefix or suffix on a PL number. They will also peed to sim and date the form bere	equire oval or The glasses/contain ern it's because the patien te the has an unchang form.	nt named on this optical voucher ged prescription but has glasses nts provided:	distance pair and / or	near pair or bifocal / varifocal anged prescription e unserviceable due to fair wear an	d tear
Exception processing should be crossed if the form does not meet the normal GOS rules e.g. no patient signature due to uncollected glasses.	<i>boxed</i> <i>centre</i> Actual retai cost of <i>ince in</i> If ess than prequa		es <sup>9</sup> mm Spec follows:1 <sup>3</sup> £	ial facial characteristics Pr ial facial characteristics <sup>at</sup> pair 2 <sup>nd</sup> pair 	Total     £     (1)     +
Cross the type(s) of glasses being supplied and whether it is a new prescription or fair wear and tear.	Patient's contributi	and supplement(s) <i>(specified a</i> on as shown by <b>box B</b> of HC3 ( ses / contact lenses <i>(1 or 2 - w</i> /	(if applicable)	7.50+£	£ 67.50 (2) £ (3) £ 67.50 (4)
Enter the number of prisms and tints being claimed for each pair if applicable. Enter box centre distance in mm if small glasses supplement is being claimed and enter a cross for special facial characteristics or prism controlled bifocal supplements where applicable.	DECLARATION I claim payment sh is correct and com withhold informatio or civil proceedings England. I can find	own above under the NHS (Opplete and that this is the original no or provide false or misleadings. I understand that my persona out more about my rights at: ht hair supplied: 3 1 0 3 2	tical Charges and Payment form as signed by the resp information, disciplinary ac I data will be processed by tps://www.england.nhs.uk/o	ts) R gulations 2013. I declare that bective patient, or other person as i ction may be taken against me and PCSE (Capita) to verify this Claim contect-us/privacy-notice/ or by cor	the information given on this form appropriate. I understand that if I I may be liable to prosecution and and the relevant controller is NHS
<ul> <li>Enter retail cost in row 1 but only if it is less than voucher value</li> <li>Enter voucher value(s) for 1st Pair, 2nd</li> <li>If eligibility is due to HC3, enter the value of patient's contribution shown on their certificate in row 3</li> <li>Enter Total Claim value in row 4</li> </ul>	Supplier's P name: P Organisation number: A Part 4 write I confirm that I hav mber on the date shown	e received distance pair an above, and used an NHS optic	al voucher.	ARATION Accal / varifocal pair of glasses or	pairs of contact lenses,**
contact le you	have information on this		l eligible. If I am not the sar	collection of my glasses/contact len me patient's parent or patients care	
The Supplier Signatory must be enter:	u are I am the patien	it patient's parent patien			X same address as patient
Their signature     Claims cannot be processed without the     respon	ning, arent, rer or arson Signature**: asible	Sign			Date: 31032021
correct 5 character ODS code. The link below can help you find the correct ODS code for your practice: https://odsportal.digital.nhs.uk/ Organisation/Search	f <i>give</i> name Address:				>         >
Cross the type of glasses supplied.					-
If the person signing is someone other than the patient, then a cross ( <b>x</b> ) must be placed against 'patient's parent' or 'patient's carer or guardian' box' and the name of the signatory entered. A cross ( <b>x</b> ) should be place in the 'same address as patient' box where appropriate.					



Did you know you can submit GOS claims electronically through PCSE Online? PCSE Online validates the claim in real time preventing any errors or omissions before you submit the claim.

**GOS 4 Paper Form** 

# Explained



Tips for Completing Paper GOS 4 forms

- **X** Complete using black ink.
- X In BLOCK capital letters.
- **X** Ensure that all the characters you write are centred within the boxes.
- X Make sure you complete all of the mandatory information.

Primary Care Support England

HS

England

In part 1 of the patient's details, you	GOS 4 NHS OPTICAL REPAIR/REPLACEMENT VOUCHER APPLICATION FORM 06/20													
need to enter the patient's:	You cannot get help if your glasses/contact lenses are covered by warranty, insurance or after care service. If they are not, and you are under 16, you will get a voucher towards the cost of a repair or replacement. If you are aged 16 or over, and are in one of the categories shown in Part 1, you must satisfy													
✓ Title ✓ First Name	NHS England that your glasses or contact lenses were lost or damaged because you were ill. You can wait for NHS England to approve your claim before you get the repair/replacement done or you can pay and claim a refund (see www.nhs.uk/healthcosts for more information). You can only have a refund if													
✓ Surname	NHS England agrees. Please complete this form using black ink and in BLOCK CAPITALS													
✓ Previous surname (if applicable)	Part 1 PATIENT'S DETAILS													
✓ Full address and postcode														
	"If changed Previous within the sumame*:													
All dates must be entered in the same	past 12 months         Address:         1         2         3         S         T         R         E         T         N         A         M         E         T         R         E         T         N         A         M         E         T         R         E         T         N         A         M         E         T         R         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         E         T         N         A         M         A         M         E         T         N         A         M         A         M         A         M         A         M         A													
format of (DDMMYYYY) as an example: 31032021														
51052021	'if known Date of birth. 3 1 0 3 1 9 8 8 NHS N°7: NI.IN°7: N.I.N°7:													
You must declare if you have seen														
'Evidence of the patients eligibility' or not. Simply cross 'Seen' or 'Not	signt test:													
seen'. One option MUST be crossed.														
You need to place a cross ( $\mathbf{x}$ ) in all of the	Evidence of eligibility													
eligibility boxes that apply to the patient.	which apply I am a prisoner on leave from the prison detailed below													
If applicable to the eligibility category,	circumstances Details of establishment (school / college / university / prison / local authority)													
you need to complete the name and town of the establishment.	order your walks. ESTABLISHMENT NAME													
For eligibility due to benefits, you must cross the correct box to indicate if the	XI / my partner, Income Support Universal Credit and meets the criteria. Pension Credit Guarantee Credit													
patient or their partner/someone they	or person I am dependent     Find out more at www.nhsbsa.nhs.uk/UC     on if I am under 20,													
are a dependant of if they are under 20 is the recipient of the benefit.	receive(s) or is included Income-based Income-related Employment Tax Credit and I am / we are named on a in an award of: Jobseeker's Allowance and Support Allowance valid NHS Tax Credit Exemption Certificat													
If the benefit recipient is not the patient,	Person getting the benefit / credit if not the patient:													
you must enter the name, NI Number (if known) and DOB of the person receiving														
the benefit.														
For HC2 put a cross in this box and	I am named on a valid: HC2 or HC3 certificate Certificate number: HC -													
enter certificate number. Do not cross	The HC3 (box B) shows that the voucher value will be reduced by: £													
l/my partner above.	I have been prescribed complex lenses under the NHS optical voucher scheme													
It is mandatory to cross the box and	****													
enter the relevant information for adult	explanation NHS England													
claims.														
	Part 2 PATIENT'S DECLARATION													
If the person signing is someone other than the patient, then a cross $(\mathbf{X})$ must	** If you are I confirm there is no insurance warranty or after sales service covering my lost or damaged glasses or contact lenses. I declare that the informatio													
be placed against 'patients parent' or	under 16 or have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken against me including repayment of the incapable cost of the optical voucher and payment of a penalty charge. To enable the NHS to check my entitlement, and on the basis of NHS England performing													
'patients carer or guardian' box' and the name of the signatory entered.	of signing, your parent, & Customs, NHS Digital, NHS Counter Fraud Authority, education providers, HM Prison Service, local authorities, and bodies performing function													
A cross ( <b>x</b> ) should be place in the	of their person of their behalf. I may also be contacted about this form or the test. My claim will be processed by PCSE (Capita) and the relevant controller is NH of the relevant control i													
'same address as patient' box where appropriate.	for you provided personal data on behalf of another person, they agree to me doing so, and I will draw this notice to their attention.													
	should sign I am the X patient's parent patient's carer or guardian same address as patie their name													
	and address high													

Did you know you can submit GOS claims electronically through PCSE Online? PCSE Online validates the claim in real time preventing any errors or omissions before you submit the claim.

- Tips for Completing Paper GOS 4 forms
- **X** Complete using black ink.
- X In BLOCK capital letters.
- **X** Ensure that all the characters you write are centred within the boxes.

**Primary Care Support England** X Make sure you complete all of the mandatory information. You must enter the approval code obtained from NHSBSA for adult claims Part 3 NHS ENGLAND APPROVAL For patients aged over 16 the contractor should consult NHS England to seek approval. NHS England may not pay a claim if prior approval has not and cross to confirm approval been granted The applicant's claim has been considered and is: 🔀 approved by NHS England 🗌 not approved by NHS England Approval code: 1 2 3 1 2 3 1 2 3 1 2 3 Cross the type of glasses being supplied and whether the claim is for a repair or Part 4 PATIENT'S DECLARATION the glasses are being replaced in full. I confirm that my: 🔀 distance pair 🗌 near pair 🗋 bifocal / varifocal pair of glasses / contact lenses have been 🔀 repaired 🗌 replaced I am the patient patient's parent X patient's carer or guardian X same address as patient If the person signing is someone other \*\* If you are under 16 or than the patient, then a cross (**X**) must be placed against 'patients parent' or incapable Sign 'patients carer or guardian' box' and the of signing name of the signatory entered. carer or 3 1 0 3 2 0 Signature\*\*: Date A cross (X) should be place in the other person responsible 'same address as patient' box where FIRSTNAME SURNAME for you Name appropriate. should sign and give their name Address Cross the type of glasses being supplied nd addres and whether the claim is for a repair or Part 5 SUPPLIER'S DECLARATION the glasses are being replaced in full. To be completed In accordance with the pre-cription and details below I have X repaired replaced: Exception Processing# Exception processing should be crossed supplier 🔀 distance pair 🗌 near pair 🗌 bifocal / varifocal pair of glasses / contact lenses for the person named at Part 1 of this form. if the form does not meet the normal GOS rules e.g. no patient signature due where new lens(es) are R to uncollected glasses. 5 0 1 8 0 5 0 1 0 0 1 8 0 ÷ 3 -3 required cases which 2.00 2.00 ADD You must enter the Prescription and require voucher type if the claim is for a full + approval or when it's Voucher type or / Complex Supplements: Prism Tint replacement or repair to lenses. necessarv to Voucher value appropriate to the above prescription Please enter the + or - in the boxes annotate the form. shown for the distance prescription and Parts: do not enter a + sign in the Add. 2 1 5 (2) Lens/Contact Lenses X Right Left Both \*Please If the Sph power is plano it should be write the number of 3 5 (3) Frame Front Whole 1 Side written as 0.00. lenses Complete row (1) if replacing glasses.
Complete row (2) and/or (3) for boxed centre distance in Special facial characteristics Prism controlled bifocal millimeters repairs. CLAIM • Complete row (4) if applicable. I claim under the NHS optical voucher scheme: Complete row (5) if replacing glasses. Voucher value plus any supplement(s) (sum of 1+4) Complete row (6) for repairs. 19 5 0 (6) or part(s) at current prices plus any supplement(s) (sum of 2+3+4) Only complete row (7) if the retail cost is less than voucher value. or actual retail cost of glasses / contact lenses is less If eligibility is due to HC3, enter the (8) Patient's contribution as shown by box B of certificate HC3 (if applicable) value of patient's contribution shown on their certificate in (8). 1 9 5 0 Total cialm (5 or 6, or 7 whichever is the lowest, minus 6) Enter total claim value here. DECLARATION I claim the payment shown above under the NHS (Optical Charges and Payments) Regulations 2013. 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 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 understand that my personal data will be processed by PCSE (Capita) to verify this Claim and the relevant controller is NHS England, I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy-notice/, or by contacting 0300 311 22 33. Enter the date(s) glasses were supplied The Supplier Signatory must be enter: Sign Their full name • The practice name (in 'Supplier's name') Date: 3 1 0 3 2 0 2 1 Signature: Organisation Number (ODS Code) FIRSTNAMESURNAME • Their signature Name Claims cannot be processed without the Supplier's PRACTICENAME correct 5 character ODS code. The link name: below can help you find the correct ODS Organisation A 1 A 1 A code for your practice: number: https://odsportal.digital.nhs.uk/ Organisation/Search



Did you know you can submit GOS claims electronically through PCSE Online? PCSE Online validates the claim in real time preventing any errors or omissions before you submit the claim.

su (or your pather) are named on a valid HC3 certificate for pathal heap w by the set of the set leafet HC11 - Yeley with heads of asymptotic the cost of your glasses, ask when you have your signites. Neese complete this form using black ink and in BLOCK CRAPTICS. you (or your partne

### **GOS 5 Paper Form**

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AS Y able at www

# Explained



**Tips for Completing** X Ensure that all the characters you write Paper GOS 5 forms are centred within the boxes. **Primary Care Support England** X Make sure you complete all of the mandatory information. You must enter the following patient HELP WITH THE COST OF A PRIVATE SIGHT TEST 06/20 GOS 5 details 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 Title test. For more information see leaflet HC11 – 'Help with health costs', which is available at www.nhs.uk/healthcosts. If you think you might be entitled to help ./ First Name 1 with the cost of your glasses, ask when you have your sight test Please complete this form using black ink and in BLOCK CAPITALS. ./ Surname Previous surname (if applicable) PATIENT'S DETAILS Part 1 Full address and postcode MR First names: F I R S T N A M E SURNAME Surname All dates must be entered in the same format of (DDMMYYYY) as an example: Previous \*If changed 1 2 3 STREET NAME within the surname 31032021 past 12 months CII Address T |y| Т OWN If you don't know the exact date of the last sight test, you can enter the year in Postcode: L S 1 1 0 the last 4 boxes. 3 1 0 3 1 9 8 8 NHS Nº \*: N.I.Nº7: Date of last X First test Not known sight test: ELIGIBILITY For HC3, put a cross in the relevant box X I / my partner are named on a valid HC3 certificate. Certificate number: HC3 and enter certificate number. - showing (box A) that I have to pay up to £ You need to place a cross (X) in all of the 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 - I I costs more than the NHS sight test. eligibility boxes that apply to the patient. I cannot attend a practice unaccompanied for a sight test because If applicable to the eligibility category, you need to complete the name and ESTABLISHMENT NAME town of the establishment. TOWNNAME Please choose ONE selection from the list to indicate your ethnic group (optional): White Asian or Asian British Black or Black British Other ethnic groups Mixed A cross should be placed against the British White and Black Asian or Asian British Black or Black British Chinese patient's ethnic group if they wish to Caribbean Caribbean Indian complete this section. Irish White and Black Asian or Asian British Black or Black British Any other African Pakistani African ethnic group White and Asian Any other Black Not stated Any other White Asian or Asian British background Bangladeshi background Any other mixed Any other Asian background background PATIENT'S DECLARATION Part 2 1/I you are | I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken against me including repayment of the difference between my patient contribution and the NHS sight test fee and payment of a penalty charge. To enable the NHS to check my entitlement, and on the basis of NHS England performing tasks in the public interest, my personal data may be disclosed If the person signing is someone other under 16 or incapable than the patient, then a cross (X) must of signing, to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, be placed against 'patients parent' or your parent, education providers, HM Prison Service, local authorities, and bodies performing functions on their behalf. I may also be contacted about this form or the test. My claim will be processed by PCSE (Capita) and the relevant controller is NHS England. I can find out more about my rights at: 'patients carer or guardian' box' and the carer or other persor name of the signatory entered. https://www.england.nhs.uk/contact-us/privacy-notice/ or by contacting 0300 311 22 33. Where I have provided personal data on behalf of another person, they agree to me doing so, and I will draw this notice to their attention. responsible A cross (X) should be place in the for you and give 'same address as patient' box where I am the X patient patient's parent patient's carer or guardian X same address as patient appropriate. their name and address Sign Date: 3 1 0 3 2 0 2 1 Signature\*\*: FIRSTNAME SURNAME Name S ADDR E S Address S 1 1 0 P A Postcode: 龖

X Complete using black ink.

X In BLOCK capital letters.



paper GOS types can be found on the PCSE YouTube channel. Go to YouTube and search 'PCSE'. You will also find further support on our website: www.pcse.england.nhs.uk

	<ul> <li>Complete using black ink.</li> <li>In BLOCK capital letters.</li> <li>England are centred within the boxes.</li> <li>Make sure you complete all of the mandatory information.</li> </ul>
You must enter the date the sight test took place in the format DDMMYYY.	Part 3       PERFORMER'S DECLARATION         I have tested the sight of the person and on this form on:       1032021       In the case of a re-test at less than the standard interval, please specify the appropriate code:         The patient was referred       A new or changed prescription was issued
Record an early retest code if applicable. Use code 1, 2 and 6. NOT 1.0, 2.0 and 6.0.	A statement was issued showing no prescription was required A voucher was issued:  Distance/ Bifocal voucher type: Or / Complex Supplements: Prism Tint If the sight test has been conducted by the
Cross (X) to confirm if the visit was for one patient or several patients and to indicate if this patient was the 1st, 2nd or 3rd / subsequent patient at the address.	Reading voucher type:       or / Complex Supplements:       Prism       Init       For the performer is required at the tottom of this form. Please put a cross in the box and complete the performers name and performer list number only.         This patient was the:       X 1 <sup>st</sup> patient at the address       2 <sup>nd</sup> patient at the address       3 <sup>nd</sup> or subsequent patient at the address
The performer who has conducted the sight must enter their name and Performer List number which is the GOC number and must be entered in the format 01-99999. There is no longer a prefix or suffix on a PL number. They will also need to sign and date the	To be completed by the Performer who has conducted the sight test Performer's name: Performer's list number: Performer's signature: Sign
form here, unless they are a contractor.	
If the performer is also the contractor, then a cross should be entered here to indicate this and the form should be signed in the contractor declaration section.	CLAIM         I claim for a sight test:         Lower of private charge or NHS sight test fee         Lower of the private charge or NHS domiciliary visit fee (where appropriate)         £         Maximum claimable in respect of sight test (sum of 1+2)         Patient's contribution as shown by box A of HC3         Total claim in respect of sight test (3 minus 4)
Enter the address and postcode where the sight test took place.	Address where sight test took place 1 2 3 5 T R E E T N A M E Postcode: L S 1 1 0 P A
This final declaration must be completed by the 'contractor' or' authorised signatory'. They must include: • Their Full name • Practice Name • Organisation Number (ODS Code) • The date completed • Their signature	DECLARATION         I claim the payment shown above under the NHS (Optical Charges and Payments) Regulations 2013. 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 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 understand that my personal data will be processed by PCSE (Capita) to verify this Claim and the relevant controller is NHS England. I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy-notice/, or by contacting 0300 311 22 33.         To be completed by the contractor or authorised signatory         Signature:
	Name:       FIRSTNAMESURNAME         Contractor's name:       PRACTICENAME         Organisation number:       AIAIA

I you know you can submit GOS claim ctronically through PCSE Online? PCSE line validates the claim in real time eventing any errors or omissions befor a submit the claim.

Videos showing how to complete all of the paper GOS types can be found on the PCSE YouTube channel. Go to YouTube and search 'PCSE'. You will also find further support on our website: www.pcse.england.nhs.uk 

### **GOS 6 Paper Form**

APPLICATION FOR A MOBILE N

ing black lok and in BLOCK CAPITALS

# Explained



#### Tips for Completing Paper GOS 6 forms

- X Complete using black ink.
- X In BLOCK capital letters.
- X Ensure that all the characters you write are centred within the boxes.
- X Make sure you complete all of the mandatory information.

Primary Care Support England

HS

England

You must enter the PCSE Online PVN	GOS 6 APPLICATION FOR A MOBILE NHS FUNDED SIGHT TEST 06/20
reference number for the domiciliary visit.	Please complete this form using black ink and in BLOCK CAPITALS Pre-Visit Notification reference number: P . X X 1 2 3 4 5
You must enter the following patient detailsensuring they match what you entered on the PVN. ✓ Title ✓ First Name ✓ Surname ✓ Previous surname (if applicable) ✓ Full address and postcode	Part 1     PATIENT'S DETAILS       Title:     MR       First names:     F I R S T       Surname:     S U R N A M E       *If changed within the past 12 months     Address:       1     Z       S T R E E T     N A M E
All dates must be entered in the same format of (DDMMYYYY) as an example: <b>31032021</b> If you don't know the exact date of the last sight test, you can enter the year in the last 4 boxes. You must enter the reason the patient	C       I       T       V       T       O       N       Postcode:       L       S       1       0       P       A         'If known       Date of birth:       3       1       0       3       1       9       8       NHS N° ':       NI.N° ':       NI.N° ':       Image: NI.N° ':
has given for requiring a domiciliary sight test.	ELIGIBILITY         X       I am 60 or over         I am under 16 <sup>17</sup> Evidence of eligibility
You must declare if you have seen 'Evidence of the patient's eligibility' or not. Simply cross 'Seen' or 'Not seen'. One option MUST be crossed.	I am 40 or over and am the parent / brother / sister / child of a person who has or had glaucoma     I am a full time student aged 16, 17 or 18 <sup>tr</sup> at the school / college / university below:     I am a full time student aged 16, 17 or 18 <sup>tr</sup> at the school / college / university below:     I am a prisoner on leave from the prison detailed below <sup>tr</sup> I suffer from diabetes / glaucoma – my GP's details are below     I am considered to be at risk of glaucoma by an     entitled to     opthalmologist at the hospital below     Local Authority below
You need to place a cross ( $x$ ) in all of the eligibility boxes that apply to the patient. If applicable to the eligibility category, you need to complete the name and town of the establishment.	+ an optical volucher Details of establishment (school / college / university / prison / GP / local authority / hospital) if you are in operative these groups. Ask the person who tests your to your tests your tes
For eligibility due to benefits, you must cross the correct box to indicate if the patient or their partner/someone they are a dependant of if they are under 20 is the recipient of the benefit. If the benefit recipient is not the patient, you must enter the name, NI Number and DOB of the person receiving the benefit.	istrict or person I am under 20, receive(s) or is included in an award of:       Income-based Jobseeker's Allowance       Income-related Employment and Support Allowance       Tax Credit and I am / we are named on a valid NHS Tax Credit Exemption Certificate         Name:       Income I am I am I and I am I am I and I am I and I am I a
For HC2, put a cross in the relevant box and enter certificate number. Do not cross I/my partner above.	I am named on a valid HC2 certificate <sup>11</sup> Certificate number: HC2 - I have been prescribed complex lenses under the NHS optical voucher scheme <sup>11</sup> Part 2 PATIENT'S DECLARATION
If the person signing is someone other than the patient, then a cross (X) must be placed against 'patient's parent' or 'patient's carer or guardian' box' and the name of the signatory entered. A cross (X) should be place in the 'same address as patient' box where appropriate.	** If you are under 16 or incapable of signing your parent, and give their name and address Signature**:
	Name: FIRSTNAMESURNAME   Address: ADDRESS   Postcode: L S 1 1 0 P A L -

	X Complete using black ink.											
Tips for (	Completing × In BLOCK capital letters.											
	DS 6 forms <i>x</i> Ensure that all the characters you write are centred within the boxes. Primary Care Support England											
	X       Make sure you complete all of the mandatory information.											
A cross should be placed against the	Please choose ONE selection from the list to indicate your ethnic group (optional):											
patient's ethnic group if they wish to complete this section.	White     Mixed     Asian or Asian British     Black or Black British     Other ethnic groups       British     White and Black     Asian or Asian British     Black or Black British     Chinese											
	Caribbean Indian Caribbean Irish White and Black Asian or Asian British Black or Black British Any other African Pakistani African ethnic group											
You must enter the date the sight test	Anican Paksani Anican entric group Any other White Mite and Asian Asian or Asian British Any other Black Not stated background Bangladeshi background											
took place in the format DDMMYYY.	Any other mixed Any other Asian background background											
Record an early retest code if applicable. Use code 1, 2 and 6. NOT 1.0, 2.0 and	art PERFORMER'S DECLARATION											
6.0.	have tested the sight of the person 3 1 0 3 2 0 2 1 In the case of a re-test at less than the stindard interval, please specify the appropriate code											
Cross ( $\mathbf{x}$ ) to confirm if the visit was for	I have made a domiciliary visit to conduct this sight test to one patient at the address in Part 1											
one patient or several patients and to indicate if this patient was the 1st, 2nd or 3rd / subsequent patient at the address.	$\overline{X}$ I have made a domining visit to extra the address in Part 1											
Sid / subsequent patient at the address.	► The patient was the: X 1st patient at the address 2nd patient at the address 3rd or subsequent patient at the address The patient was referred A new or changed prescription was issued											
If a voucher was issued enter the relevant voucher category as to whether	A statement was issued showing no prescription was required An unchanged prescription was issued											
the patient is receiving distance/bifocals or whether they are receiving a reading	The patient was added/substituted on the day of the visit A voucher was issued:											
voucher.	Distance/ Bifocal voucher type: or / Complex Supplements: Prism Tint X If the sight test has been conducted by the contractor only one signature is required at the software or / Complex Supplements: Prism Tint bottom of this form. Please put a cross in the											
If the performer is also the contractor, then a cross should be entered here to	box and complete the performers name and performer list number only.											
indicate this and the form should be signed in the contractor declaration	To be completed by the Performer who has conducted the sight test											
section. +	Performer's FIRSTNAMESURNAME +											
The performer who has conducted												
the sight must enter their name and Performer List number which is the GOC number and must be entered in the												
format 01-99999. There is no longer a prefix or suffix on a PL number.	Performer's Jane: 31032021											
They will also need to sign and date the form here, unless they are a contractor.	CLAIM											
	I claim:											
Cross (X) to claim the sight test fee and the appropriate domiciliary fee.	► X the domiciliary fee for the 1st or 2nd patient at the address											
Enter the address and postcode where	the domiciliary fee for the 3rd or subsequent patient at the address     Address where sight test took place     Description											
the sight test took place. Please ensure this matches what you entered on the	123         STREET         NAME         Postcode:         LS110         PA											
PVN.												
	I claim the current NHS sight test fee under the NHS (Optical Charges and Payments) Regulations 2013. 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 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 understand that my personal data will be processed by PCSE (Capita) to verify this Claim and the relevant controller is NHS England. I can find out more about my rights at: https://www.england.nhs.uk/contact-us/privacy-notice/, or by											
This final declaration must be completed by the 'contractor' or' authorised signatory'.	contacting 0300 311 22 33. To be completed by the contractor or authorised signatory											
They must include:	Sign											
Their Full name     Practice Name	Signature: Date: 31032021											
Organisation Number (ODS Code)     The date completed     The completed	Name: FIRSTNAMESURNAME											
• Their signature												
	Organisation A I A I A											
	-											

Did you know you can submit GOS claims electronically through PCSE Online? PCSE Online validates the claim in real time preventing any errors or omissions before you submit the claim.

### **Contact us**

For further support and information, please visit our website:



#### PCSE Online

www.pcse.england.nhs.uk

You can also find some really useful videos for submitting paper GOS forms on the PCE YouTube channel:



For queries relating to a particular service, please use our:



#### **Enquiry Form**

https://pcse.england.nhs.uk/contact-us/

Or alternatively, you can call our:



### Customer Support Centre



