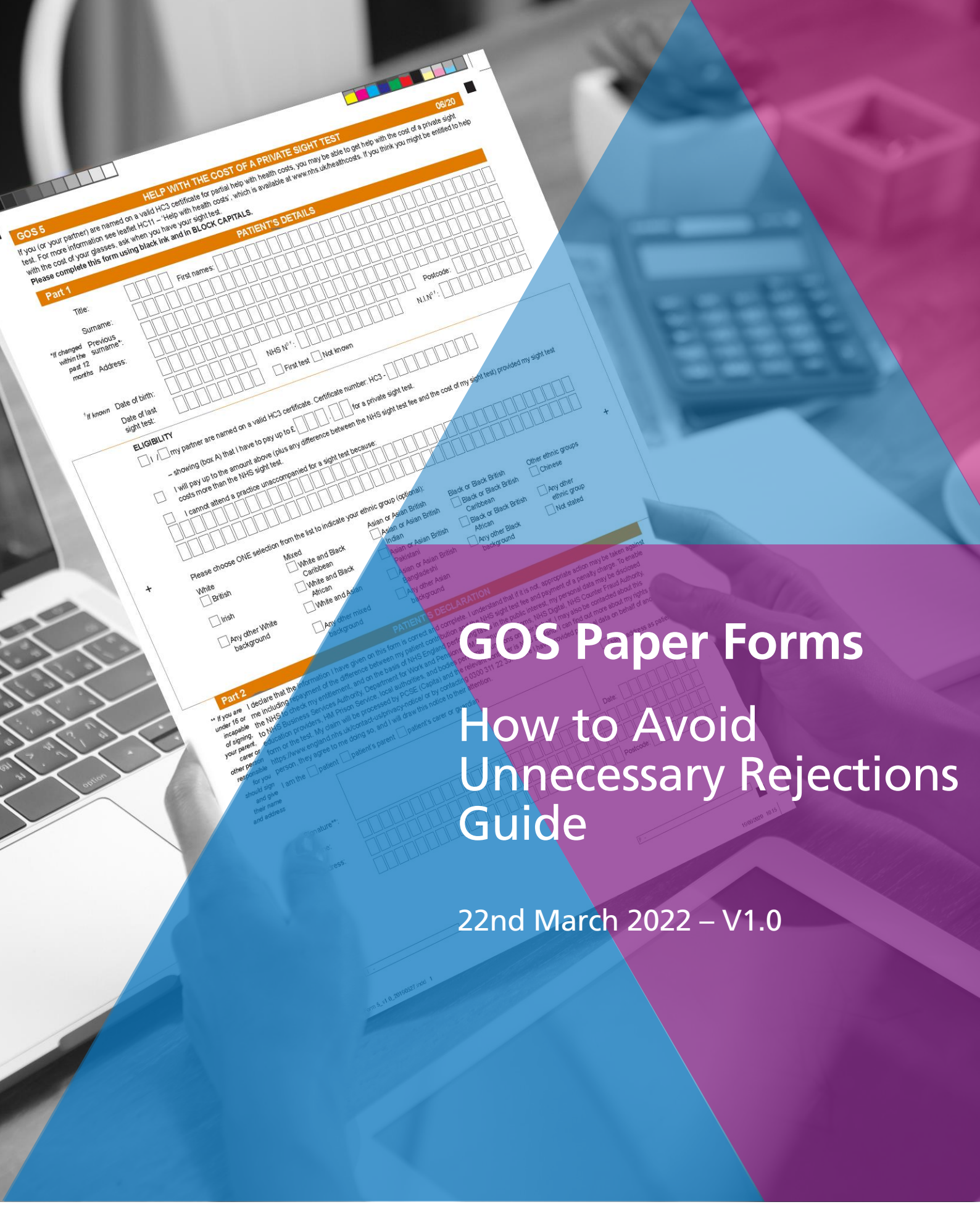

GOS Paper Forms

How to Avoid Unnecessary Rejections Guide

22nd March 2022 – V1.0

NHS England

Primary Care Support England

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Introduction

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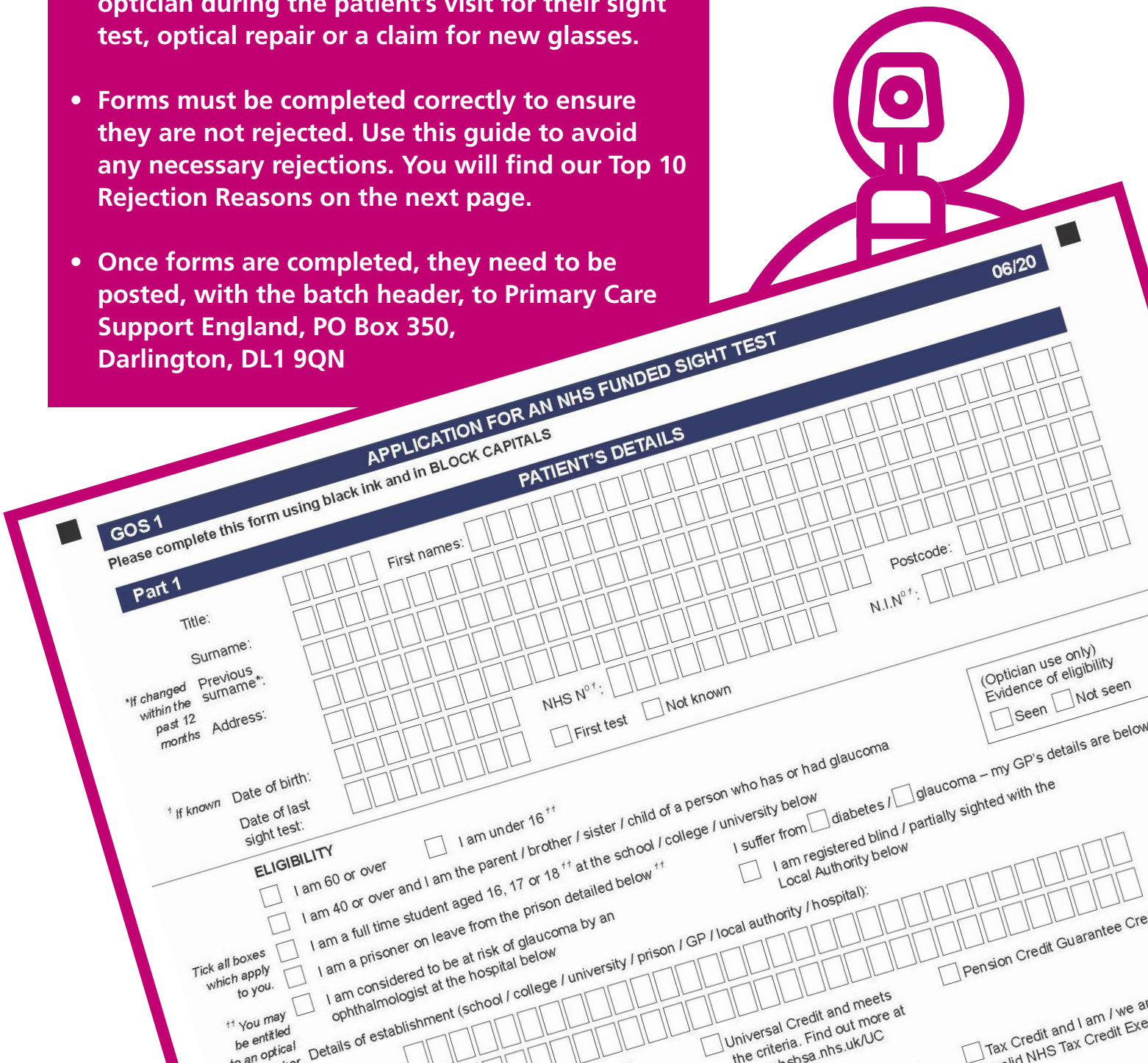
NHS England and NHS Improvement launched new style paper GOS forms on the 1st February 2021. You can order the paper GOS forms (GOS1, 3, 4, 5 and 6) from PCSE Online and the forms are delivered to the practice.

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:

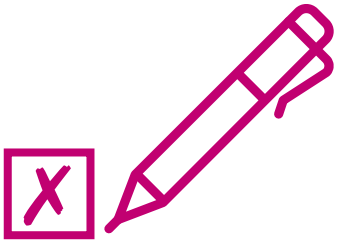
- **The appropriate form must be completed by the optician during the patient's visit for their sight test, optical repair or a claim for new glasses.**
- **Forms must be completed correctly to ensure they are not rejected. Use this guide to avoid any necessary rejections. You will find our Top 10 Rejection 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**



NHS England

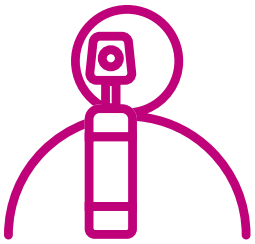
Primary Care Support England

TOP 10 THINGS TO REMEMBER TO AVOID UNECESSARY REJECTIONS



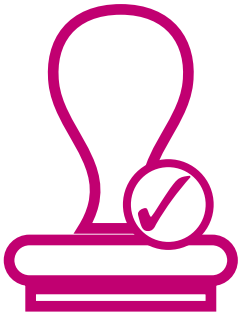
The second voucher type is optional and should only be provided if a first voucher type has been provided. Either provide a second voucher code or select the complex lens option. Valid second voucher type codes are: A, B, C, D.
(GOS 1, 5 & 6)

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)

NHS England

Primary Care Support England

TOP 10 THINGS TO REMEMBER TO AVOID UNECESSARY REJECTIONS

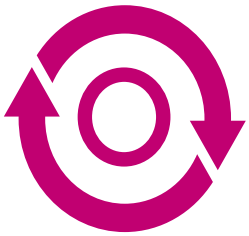
Please complete the evidence of eligibility box and select either seen or not seen.
(All GOS claims)

01-2345

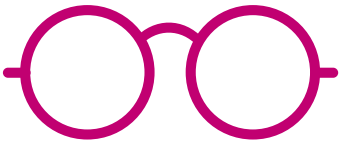
Please ensure the performers list number is provided.
(GOS 1,3,5,6)

JANE SMITH

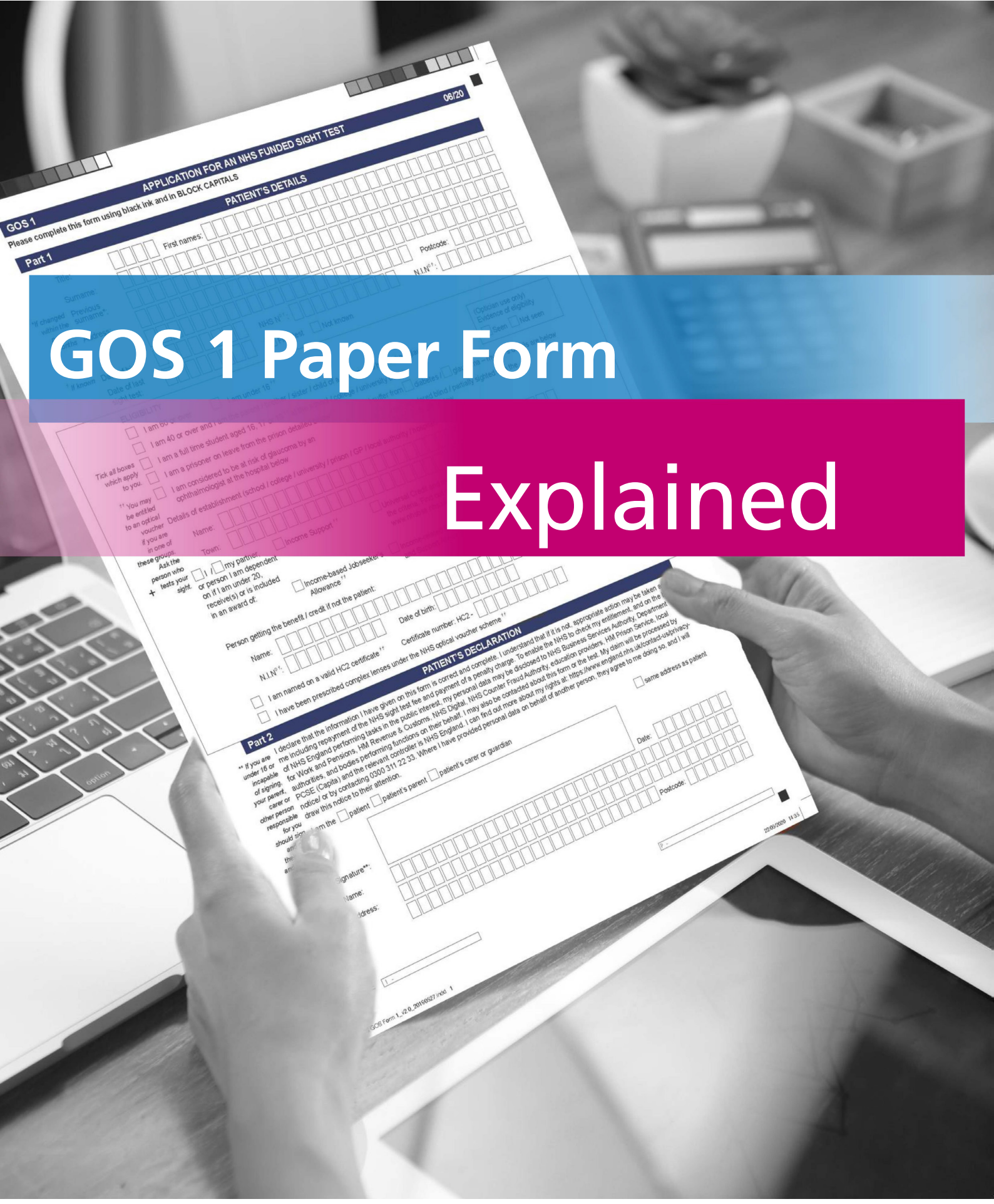
Please ensure the signatory name under the patient's declaration is provided.
(All GOS claims)



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 Explained

NHS England

Primary Care Support England

Tips for Completing Paper GOS 1 forms

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

NHS England

Primary Care Support England

In part 1 of the patients details, you need to enter the patients:

- ✓ Title
- ✓ First Name
- ✓ Surname
- ✓ Previous surname (if applicable)
- ✓ Full address and postcode

All dates must be entered in the same format of (DDMMYYYY) as an example: **31032021**
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 declare if you have seen **'Evidence of the patients eligibility'** or not. Simply cross **'Seen'** or **'Not seen'**. One option **MUST** be crossed.

You need to place a cross (✗) 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.

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 (if known) and DOB of the person receiving the benefit.

For HC2 put a cross in this box and enter certificate number. **Do not cross I/my partner above**.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

GOS 1 — **APPLICATION FOR AN NHS FUNDED SIGHT TEST** — 06/20

Please complete this form using black ink and in BLOCK CAPITALS

Part 1 — PATIENT'S DETAILS

Title: MR | First names: FIRST NAME

Surname: SURNAME

If changed within the past 12 months — Previous surname: 123 STREET NAME

Address: TOWN / CITY | Postcode: LS11 0PA

†If known — Date of birth: 31 03 1988 | NHS N°†: | N.I.N°†:

Date of last sight test: 2020 | ☐ First test ☐ Not known

ELIGIBILITY

Tick all boxes which apply to you.

- ☐ 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 glaucoma
- ☐ I am a full time student aged 16, 17 or 18 †† at the school / college / university below
- ☐ I am a prisoner on leave from the prison detailed below ††
- ☐ I am considered to be at risk of glaucoma by an ophthalmologist at the hospital below

(Optician use only) Evidence of eligibility: ☐ Seen ☒ Not seen

I suffer from ☐ diabetes / ☐ glaucoma – my GP's details are below

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

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

Details of establishment (school / college / university / prison / GP / local authority / hospital):

Name: ESTABLISHMENT NAME

Town: TOWN NAME

☒ I / ☐ my partner, or person I am dependent on if I am under 20, receive(s) or is included in an award of:

- ☒ Income Support ††
- ☐ Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC
- ☐ Pension Credit Guarantee Credit ††
- ☐ 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 ††

Person getting the benefit / credit if not the patient:

Name:

N.I.N°†: | Date of birth:

☐ I am named on a valid HC2 certificate †† | Certificate number: HC2 - 123456789

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

Part 2 — PATIENT'S DECLARATION

** 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 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 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 to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, 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: 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.

I am the ☒ patient ☐ patient's parent ☐ patient's carer or guardian | ☐ same address as patient

Signature**: Sign | Date: 31032021

Name: FIRSTNAME SURNAME

Address: ADDRESS | Postcode: LS11 0PA

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.

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

Tips for Completing Paper GOS 1 forms

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

NHS England

Primary Care Support England

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 Caribbean	☐ Asian or Asian British Indian	☐ Black or Black British Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Asian or Asian British Pakistani	☐ Black or Black British African	☐ Any other ethnic group
☐ Any other White background	☐ White and Asian	☐ Asian or Asian British Bangladeshi	☐ Any other Black background	☐ Not stated
	☐ Any other mixed background	☐ Any other Asian background		

You must enter the date the sight test took place in the format DDMMYYY.

Record an early retest code if applicable. **For example**: Use code 1, 2 and 6. **NOT** 1.0, 2.0 and 6.0.

If the patient is issued a voucher you should insert the appropriate voucher category in these boxes.

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.

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.

This final declaration must be completed by the **'contractor' or 'authorised signatory'**.

They must include:

- ✓ Their signature
- ✓ The date completed
- ✓ Their name
- ✓ The contractor's name (i.e. the practice name)
- ✓ Organisation number (ODS code)

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

Part 3 PERFORMER'S DECLARATION

I have tested the sight of the person named on this form on: 31 03 2021

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

☐ The patient was referred

☐ A statement was issued showing no prescription was required

☐ A voucher was issued:

☐ A new or changed prescription was issued

☐ An unchanged prescription was issued

Distance/ Bifocal voucher type: A or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

Reading voucher type: ☐ or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

☐ If the sight test has been conducted by the contractor only one signature is required at the bottom of this form. Please put a cross in the box and complete the performers name and performer list number only.

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

Performer's name: FIRSTNAME SURNAME

Performers list number: 01-99999

Performer's signature: Sign

Date: 31 03 2021

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. 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: Sign

Date: 31 03 2021

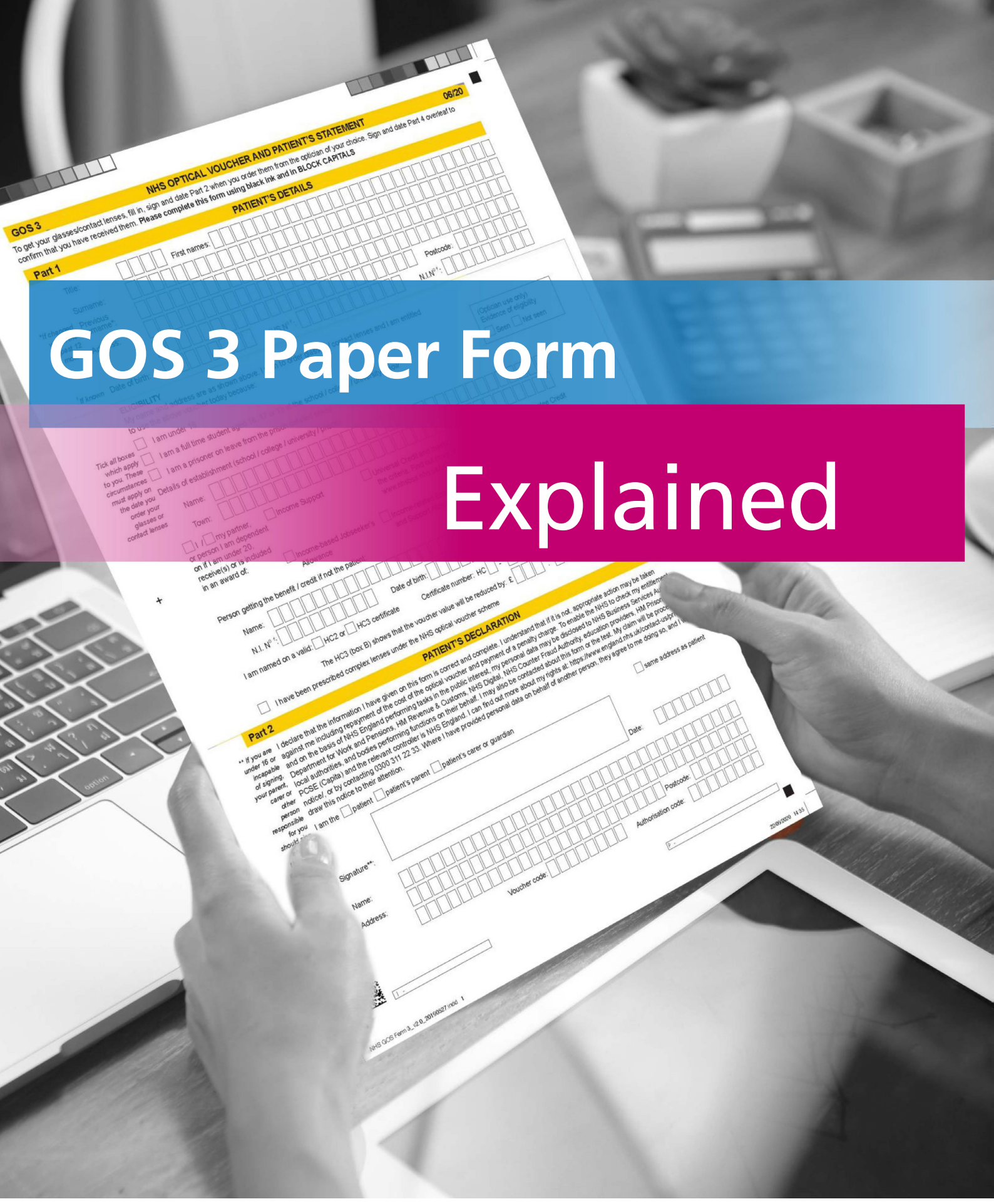
Name: FIRSTNAME SURNAME

Contractor's name: PRACTICE NAME

Organisation number: A1A1A

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.

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 3 Paper Form

Explained

NHS England

Primary Care Support England

Tips for Completing Paper GOS 3 forms

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

NHS England

Primary Care Support England

In part 1 of the patient's details, you need to enter the patient's:

- ✓ Title
- ✓ First Name
- ✓ Surname
- ✓ Previous surname (if applicable)
- ✓ Full address and postcode

All dates must be entered in the same format of (DDMMYYYY) as an example: **31032021**

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.

You need to place a cross (✗) 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.

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 (if known) and DOB of the person receiving the benefit.

For HC2 put a cross in this box and enter certificate number. **Do not cross I/my partner above**.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

GOS 3 — NHS OPTICAL VOUCHER AND PATIENT'S STATEMENT — 06/20

To get your glasses/contact lenses, fill in, sign and date Part 2 when you order them from the optician of your choice. Sign and date Part 4 overleaf to confirm that you have received them. **Please complete this form using black ink and in BLOCK CAPITALS**

Part 1 — PATIENT'S DETAILS

Title: MR First names: FIRST NAME

Surname: SURNAME

If changed within the past 12 months Previous surname: 123 STREET NAME

Address: TOWN / CITY

Postcode: LS11 0PA

*If known Date of birth: 31 03 1988 NHS N°†: N.I.N°†:

ELIGIBILITY

My name and address are as shown above. I wish to order glasses / contact lenses and I am entitled to use the above voucher today because:

(Optician use only) Evidence of eligibility: [X] Seen [ ] Not seen

Tick all boxes which apply to you. These circumstances must apply on the date you order your glasses or contact lenses

- [ ] I am under 16
- [X] I am a full time student aged 16, 17 or 18 at the school / college / university below
- [ ] I am a prisoner on leave from the prison detailed below

Details of establishment (school / college / university / prison):

Name: ESTABLISHMENT NAME

Town: TOWN NAME

+

[X] I / [ ] my partner, or person I am dependent on if I am under 20, receive(s) or is included in an award of:

- [ ] Income Support
- [ ] Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC
- [ ] Pension Credit Guarantee Credit
- [ ] 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

Person getting the benefit / credit if not the patient:

Name:

N.I. N°†: Date of birth:

I am named on a valid: [ ] HC2 or [ ] HC3 certificate Certificate number: HC -

The HC3 (box B) shows that the voucher value will be reduced by: £ .

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

Part 2 — PATIENT'S DECLARATION

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 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 tasks in the public interest, my personal data may be disclosed to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, 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: 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.

*** 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 [X] patient's carer or guardian [ ] same address as patient

Signature**: Sign Date: 31 03 2021

Name: FIRSTNAME SURNAME

Address: ADDRESS

Postcode: LS11 0PA

Voucher code: Authorisation code:

I - P -

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.

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

Tips for Completing Paper GOS 3 forms

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

NHS England

Primary Care Support England

You will need to insert the value in the prism cimal place and use in, ot, up, dn for the direction, if there are 2 components then use the second row for the other component. Please enter the + or - in the boxes shown for the distance prescription and do not enter a + sign in the Add.

If the Sph power is plano it should be written as **0.00**

Enter the relevant categories for the voucher types being prescribed and cross Prism or Tint if supplements being applied.

The performer who is completing the 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 need to sign and date the form here.

Exception processing should be crossed if the form does not meet the normal GOS rules e.g. no patient signature due to uncollected glasses.

Cross the type(s) of glasses being supplied and whether it is a new prescription or fair wear and tear.

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.

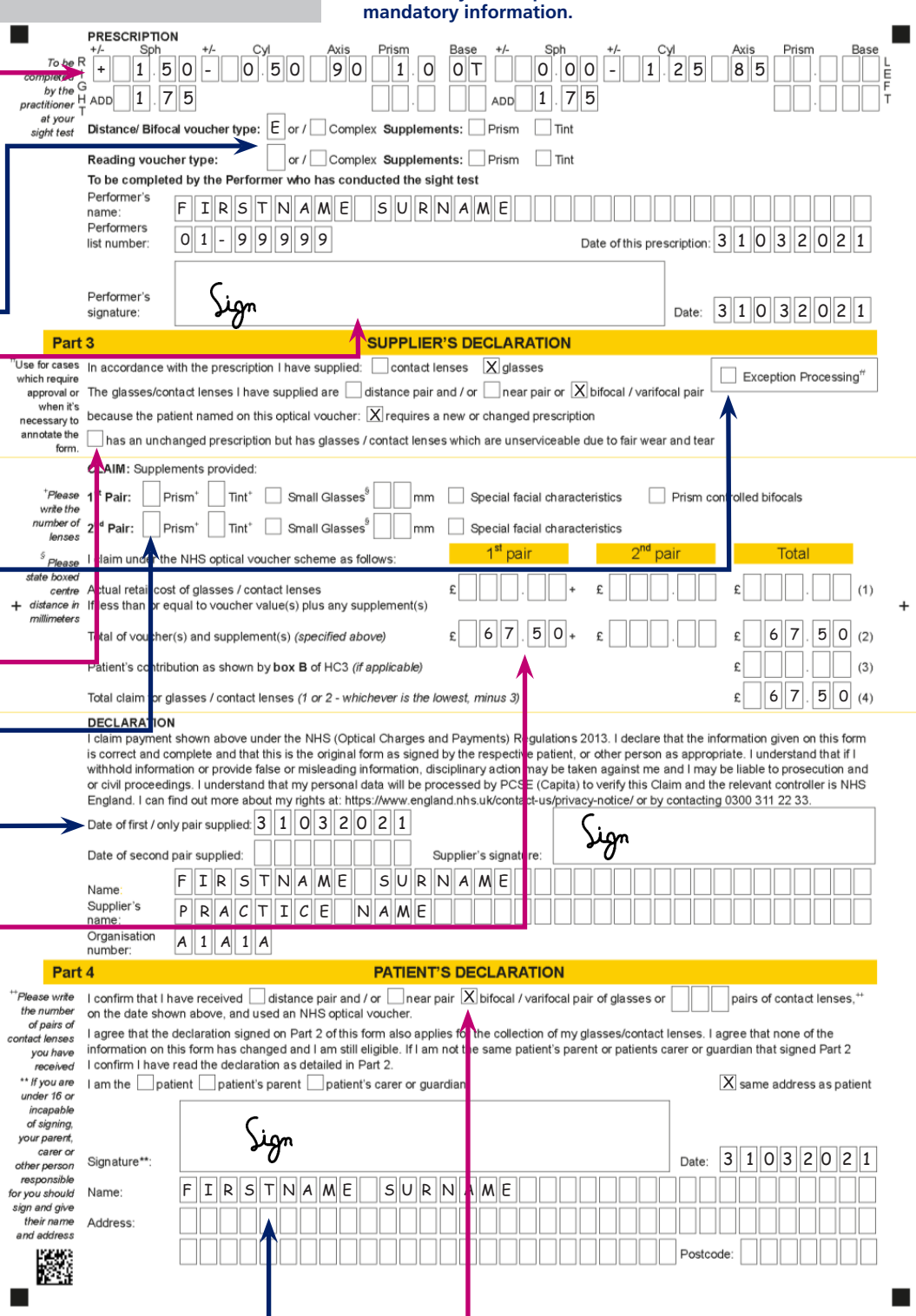
- Enter retail cost in row 1 but only if it is less than voucher value
- Enter voucher value(s) for 1st Pair, 2nd
- If eligibility is due to HC3, enter the value of patient's contribution shown on their certificate in row 3
- Enter Total Claim value in row 4

Enter the date(s) glasses were supplied
The Supplier Signatory must be enter:
- Their full name
- The practice name (in 'Supplier's name')
- Organisation Number (ODS Code)
- Their signature

Claims cannot be processed without the 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

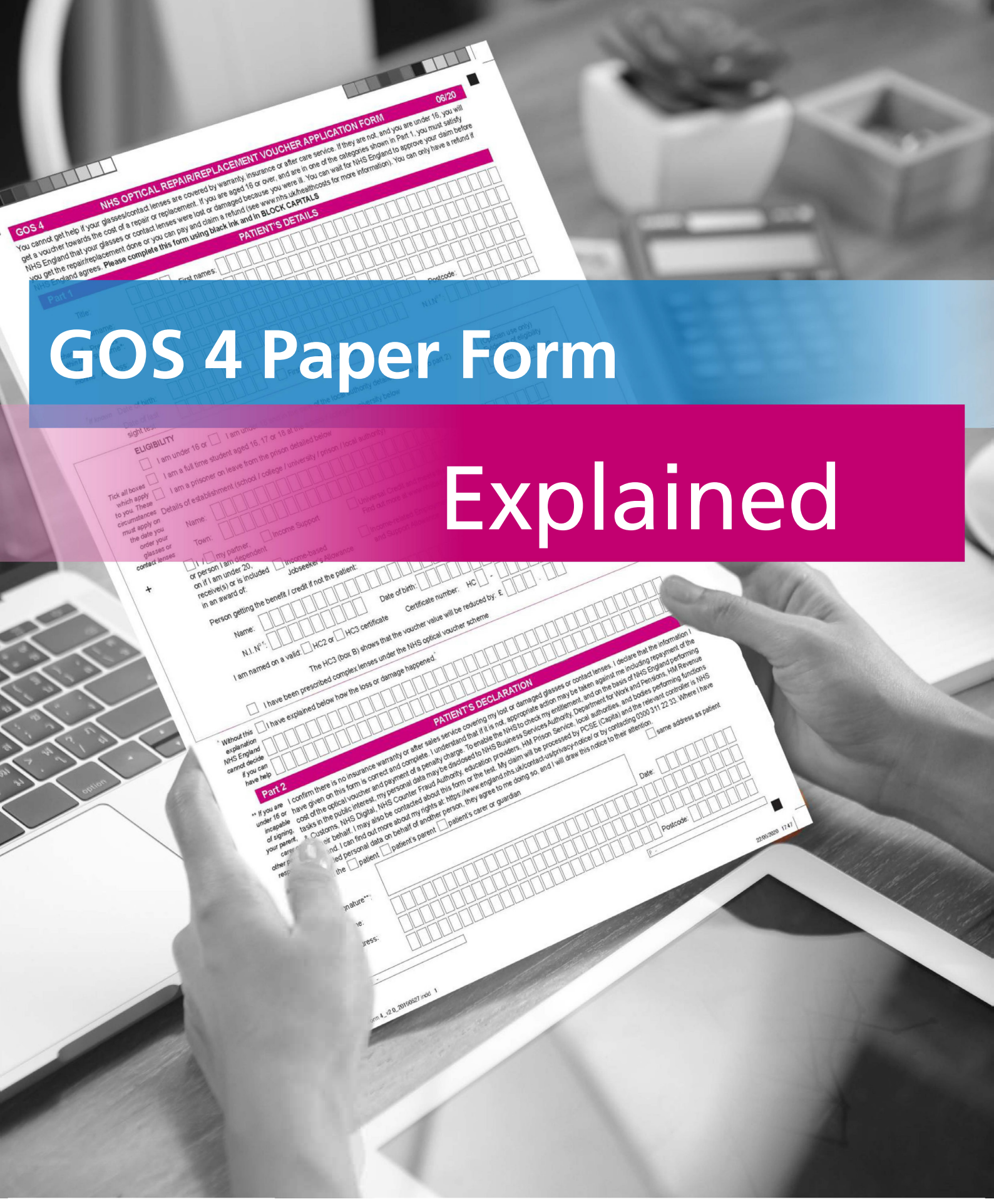
Cross the type of glasses supplied.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patient's parent' or 'patient's carer or guardian' box' and the name of the signatory entered.
A cross (✗) 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.

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 4 Paper Form

Explained

NHS England

Primary Care Support England

Tips for Completing Paper GOS 4 forms

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

NHS England

Primary Care Support England

In part 1 of the patient's details, you need to enter the patient's:

- ✓ Title
- ✓ First Name
- ✓ Surname
- ✓ Previous surname (if applicable)
- ✓ Full address and postcode

All dates must be entered in the same format of (DDMMYYYY) as an example: **31032021**

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.

You need to place a cross (✗) 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.

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 (if known) and DOB of the person receiving the benefit.

For HC2 put a cross in this box and enter certificate number. **Do not cross I/my partner above.**

It is mandatory to cross the box and enter the relevant information for adult claims.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

GOS 4 NHS OPTICAL REPAIR/REPLACEMENT VOUCHER APPLICATION FORM 06/20

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 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 NHS England agrees. **Please complete this form using black ink and in BLOCK CAPITALS**

Part 1 PATIENT'S DETAILS

Title: MR First names: FIRST NAME

Surname: SURNAME

If changed within the past 12 months Previous surname:

Address: 123 STREET NAME

CITY TOWN Postcode: LS1 1OPA

*If known Date of birth: 31 03 1988 NHS N°†: N.I.N°†:

Date of last sight test: ☐ First test ☒ Not known

ELIGIBILITY

☒ I am under 16 or ☐ I am under 18 and in the care of the local authority detailed below (go to part 2)

(Optician use only) Evidence of eligibility ☒ Seen ☐ Not seen

Tick all boxes which apply to you. These circumstances must apply on the date you order your glasses or contact lenses

☐ I am a full time student aged 16, 17 or 18 at the school / college / university below

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

Details of establishment (school / college / university / prison / local authority)

Name: ESTABLISHMENT NAME

Town: TOWN NAME

+ ☒ I / ☐ my partner, or person I am dependent on if I am under 20, receive(s) or is included in an award of: ☐ Income Support ☐ Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC ☐ Pension Credit Guarantee Credit ☐ 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 +

Person getting the benefit / credit if not the patient:

Name:

N.I. N°†: Date of birth:

I am named on a valid: ☐ HC2 or ☐ HC3 certificate Certificate number: HC -

The HC3 (box B) shows that the voucher value will be reduced by: £ .

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

^ With this explanation NHS England cannot decide if you can have help ☐ I have explained below how the loss or damage happened.^

Part 2 PATIENT'S DECLARATION

** 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 confirm there is no insurance warranty or after sales service covering my lost or damaged glasses or contact lenses. 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 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 tasks in the public interest, my personal data may be disclosed to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, 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: 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.

I am the ☒ patient ☐ patient's parent ☐ patient's carer or guardian ☐ same address as patient

Signature**: Sign Date: 31 03 2021

Name: FIRSTNAME SURNAME

Address: ADDRESS

Postcode: LS1 1OPA

I - P -

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.

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

Tips for Completing Paper GOS 4 forms

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

NHS England

Primary Care Support England

You must enter the approval code obtained from NHSBSA for adult claims and cross to confirm approval

Cross the type of glasses being supplied and whether the claim is for a repair or the glasses are being replaced in full.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

Cross the type of glasses being supplied and whether the claim is for a repair or the glasses are being replaced in full.

Exception processing should be crossed if the form does not meet the normal GOS rules e.g. no patient signature due to uncollected glasses.

You must enter the Prescription and voucher type if the claim is for a full replacement or repair to lenses.

Please enter the + or - in the boxes shown for the distance prescription and do not enter a + sign in the Add.

If the Sph power is plano it should be written as 0.00.

- Complete row (1) if replacing glasses.
- Complete row (2) and/or (3) for repairs.
- Complete row (4) if applicable.

Complete row (5) if replacing glasses.
Complete row (6) for repairs.
Only complete row (7) if the retail cost is less than voucher value.

If eligibility is due to HC3, enter the value of patient's contribution shown on their certificate in (8).

Enter total claim value here.

Enter the date(s) glasses were supplied
The Supplier Signatory must be enter:
- Their full name
- The practice name (in 'Supplier's name')
- Organisation Number (ODS Code)
- Their signature

Claims cannot be processed without the 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

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 been granted.

The applicant's claim has been considered and is: [X] approved by NHS England [ ] not approved by NHS England

Approval code: 1 2 3 1 2 3 1 2 3 1 2 3

Part 4 PATIENT'S DECLARATION

I confirm that my: [X] distance pair [ ] near pair [ ] bifocal / varifocal pair of glasses / contact lenses have been [X] repaired [ ] replaced

I am [ ] the patient [ ] patient's parent [X] patient's carer or guardian [X] same address as patient

** 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**: Sign

Date: 31 03 2021

Name: FIRSTNAME SURNAME

Address:

Postcode:

Part 5 SUPPLIER'S DECLARATION

To be completed by the supplier where new lens(es) are required

In accordance with the prescription and details below I have [X] repaired [ ] replaced: [ ] Exception Processing#

[X] distance pair [ ] near pair [ ] bifocal / varifocal pair of glasses / contact lenses for the person named at Part 1 of this form.

	+/-	Sph	+/-	Cyl	Axis	Prism	Base	+/-	Sph	+/-	Cyl	Axis	Prism	Base
RIGHT	+	3.50	-	1.80				+	3.50	-	1.00	180		
	ADD	2.00						ADD	2.00					

+ Use cases which require approval or when it's necessary to annotate the form.

Voucher type: [ ] or / [ ] Complex Supplements: [ ] Prism [ ] Tint +

Voucher value appropriate to the above prescription £ (1)

Parts:

*Please write the number of lenses

Lens/Contact Lenses [X] Right [ ] Left [ ] Both £12.15 (2)

Frame [ ] Front [ ] Whole [1] Side £7.35 (3)

§Please state boxed centre distance in millimeters

[ ] Special facial characteristics [ ] Prism controlled bifocal £ (4)

CLAIM

I claim under the NHS optical voucher scheme:

Voucher value plus any supplement(s) *(sum of 1+4)* £ (5)

or part(s) at current prices plus any supplement(s) *(sum of 2+3+4)* £19.50 (6)

or actual retail cost of glasses / contact lenses is less £ (7)

Patient's contribution as shown by **box B** of certificate HC3 *(if applicable)* £ (8)

Total claim (5 or 6, or 7 whichever is the lowest, minus 8) £19.50

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.

Signature: Sign

Date: 31 03 2021

Name: FIRSTNAME SURNAME

Supplier's name: PRACTICE NAME

Organisation number: A1A1A

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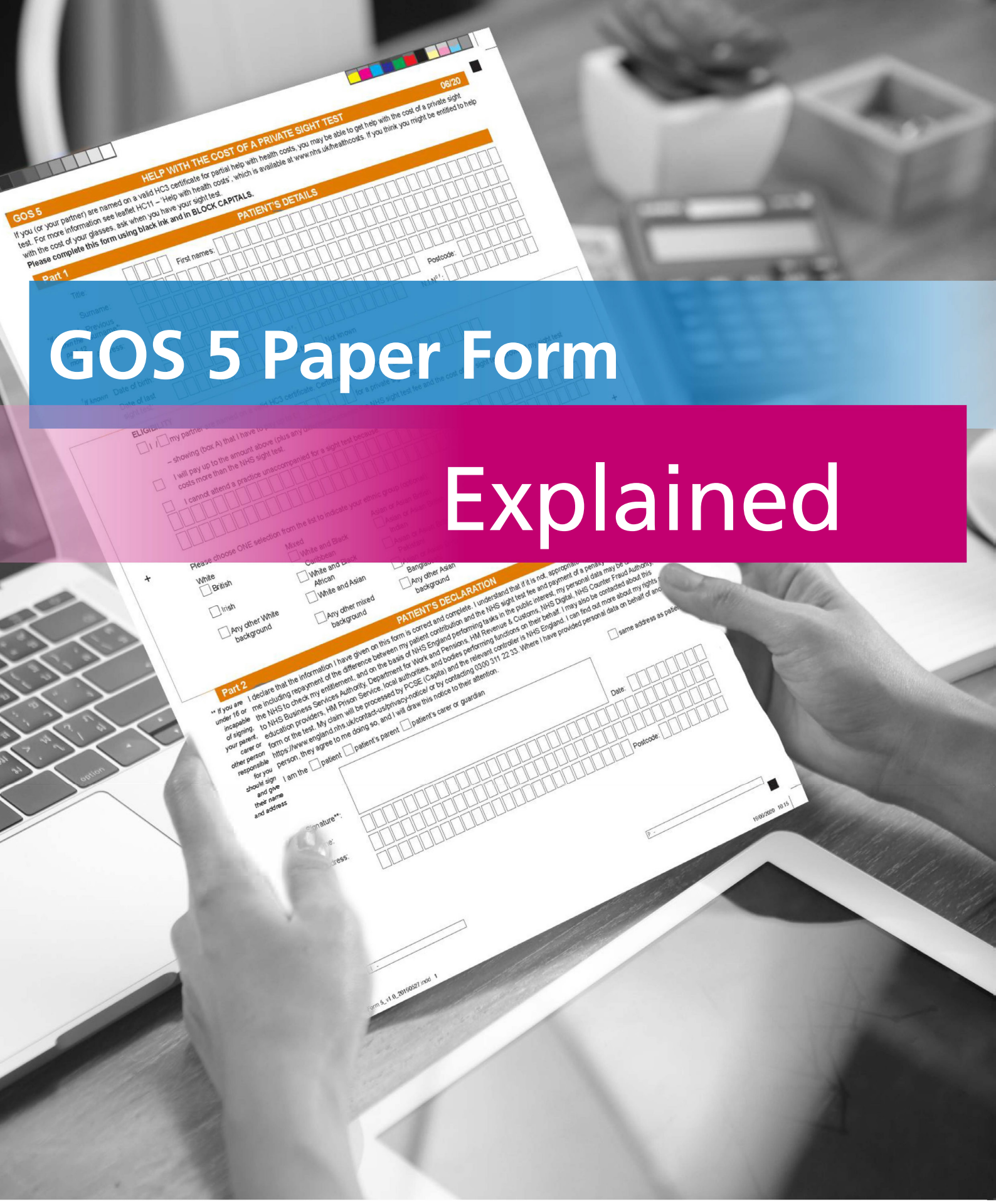
Videos showing how to complete all of the paper GOS types can be found on the PCSE YouTube channel. Go to YouTube and search 'PCSE'. You will also find further support on our website: www.pcse.england.nhs.uk



GOS 5 Paper Form

Explained

NHS England

Primary Care Support England

Tips for Completing Paper GOS 5 forms

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

NHS England

Primary Care Support England

You must enter the following patient details:

- ✓ Title
- ✓ First Name
- ✓ Surname
- ✓ Previous surname (if applicable)
- ✓ Full address and postcode

All dates must be entered in the same format of (DDMMYYYY) as an example:

31032021

If you don't know the exact date of the last sight test, you can enter the year in the last 4 boxes.

For HC3, put a cross in the relevant box and enter certificate number.

You need to place a cross (✗) 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.

A cross should be placed against the patient's ethnic group if they wish to complete this section.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patients parent' or 'patients carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

GOS 5 — HELP WITH THE COST OF A PRIVATE SIGHT TEST — 06/20

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 at www.nhs.uk/healthcosts. 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

Title: MR | First names: FIRST NAME

Surname: SURNAME

If changed within the past 12 months — Previous surname: 123 STREET NAME

Address: CITY TOWN

Postcode: LS11 0PA

If known — Date of birth: 31031988 | NHS No: | N.I.No*:

Date of last sight test: | [X] First test [ ] Not known

ELIGIBILITY

[X] I / [ ] my partner are named on a valid HC3 certificate. Certificate number: HC3 -

– showing (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 costs more than the NHS sight test.

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

ESTABLISHMENT NAME

TOWN NAME

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 Caribbean	[ ] Asian or Asian British Indian	[ ] Black or Black British Caribbean	[ ] Chinese
[ ] Irish	[ ] White and Black African	[ ] Asian or Asian British Pakistani	[ ] Black or Black British African	[ ] Any other ethnic group
[ ] Any other White background	[ ] White and Asian	[ ] Asian or Asian British Bangladeshi	[ ] Any other Black background	[ ] Not stated
	[ ] Any other mixed background	[ ] Any other Asian background		

Part 2 — PATIENT'S DECLARATION

** 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 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 to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, 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: 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.

I am the [X] patient [ ] patient's parent [ ] patient's carer or guardian [X] same address as patient

Signature**: Sign | Date: 31032021

Name: FIRSTNAME SURNAME

Address: ADDRESS

Postcode: LS11 0PA

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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

Tips for Completing Paper GOS 5 forms

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

NHS England

Primary Care Support England

You must enter the date the sight test took place in the format DDMMYYY.

Record an early retest code if applicable. Use code 1, 2 and 6. NOT 1.0, 2.0 and 6.0.

Cross (✗) 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.

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.

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.

Enter the address and postcode where the sight test took place.

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

Part 3 PERFORMER'S DECLARATION

I have tested the sight of the person named on this form on: 31032021

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

- ☐ The patient was referred
- ☐ A statement was issued showing no prescription was required
- ☐ A voucher was issued:
- ☐ A new or changed prescription was issued
- ☐ An unchanged prescription was issued

Distance/ Bifocal voucher type: ☐ or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

Reading voucher type: ☐ or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

☐ If the sight test has been conducted by the contractor only one signature is required at the bottom of this form. Please put a cross in the box and complete the performers name and performer list number only.

This patient was the:

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

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

Performer's name: FIRSTNAME SURNAME

Performers list number:

Performer's signature: Sign

Date: 31032021

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 *(where appropriate)*	£ (2)
Maximum claimable in respect of sight test *(sum of 1+2)*	£ (3)
Patient's contribution as shown by **box A** of HC3	£ (4)
Total claim in respect of sight test *(3 minus 4)*	£

Address where sight test took place

123 STREET NAME

Postcode: LS11 0PA

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: Sign

Date: 31032021

Name: FIRSTNAME SURNAME

Contractor's name: PRACTICE NAME

Organisation number: A1A1A

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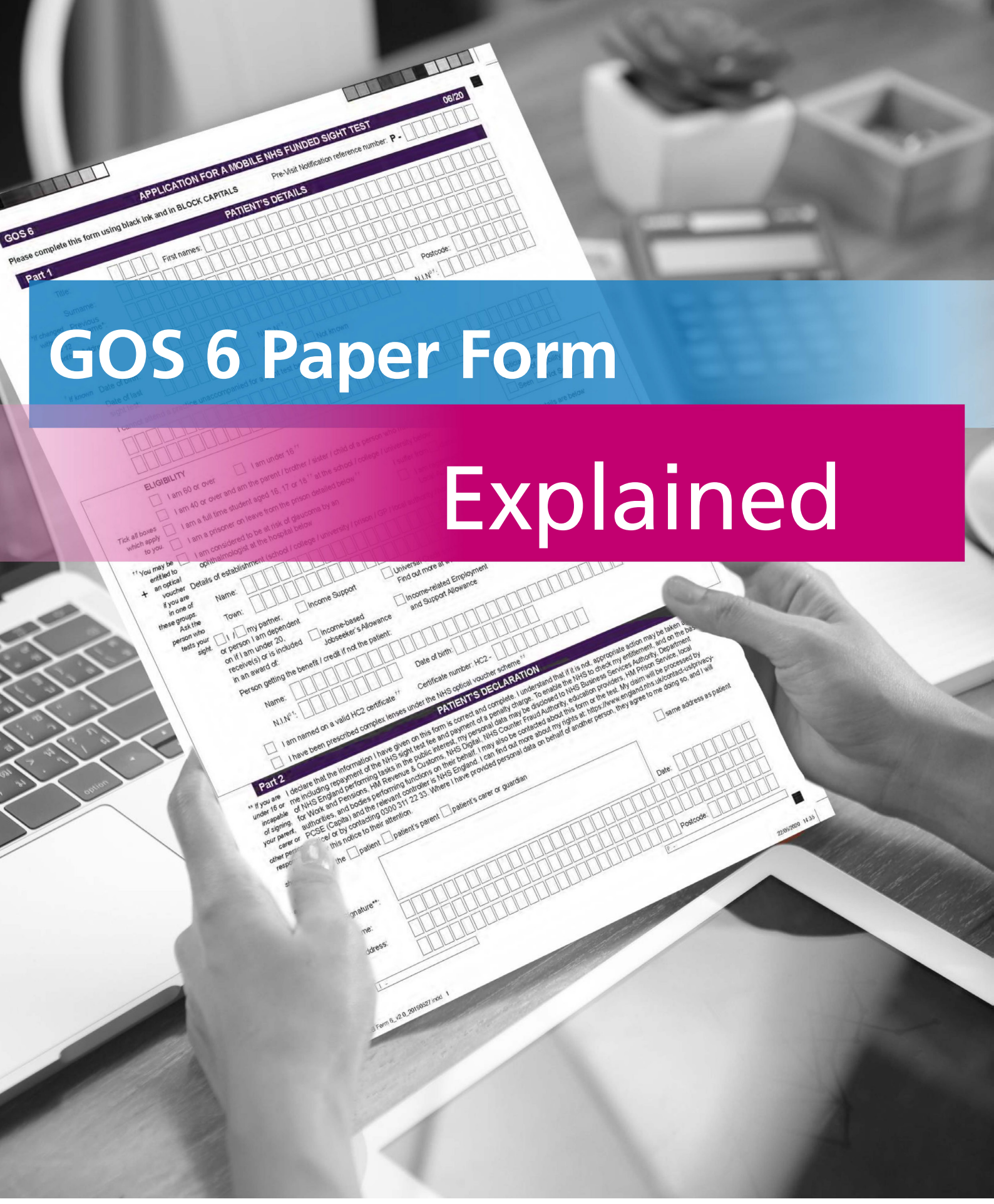
Videos showing how to complete all of the paper GOS types can be found on the PCSE YouTube channel. Go to YouTube and search 'PCSE'. You will also find further support on our website: www.pcse.england.nhs.uk



GOS 6 Paper Form Explained

NHS England

Primary Care Support England

Tips for Completing Paper GOS 6 forms

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

NHS England

Primary Care Support England

You must enter the PCSE Online PVN reference number for the domiciliary visit.

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

All dates must be entered in the same format of (DDMMYYYY) as an example:

31032021

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 has given for requiring a domiciliary sight test.

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.

You need to place a cross (✗) 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.

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.

For HC2, put a cross in the relevant box and enter certificate number. Do not cross I/my partner above.

If the person signing is someone other than the patient, then a cross (✗) must be placed against 'patient's parent' or 'patient's carer or guardian' box' and the name of the signatory entered.

A cross (✗) should be place in the 'same address as patient' box where appropriate.

GOS 6 APPLICATION FOR A MOBILE NHS FUNDED SIGHT TEST 06/20

Please complete this form using black ink and in BLOCK CAPITALS

Pre-Visit Notification reference number: P - XX123456

Part 1 PATIENT'S DETAILS

Title: MR

First names: FIRST NAME

Surname: SURNAME

If changed within the past 12 months Previous surname*:

Address: 123 STREET NAME

CITY TOWN

Postcode: LS11 0PA

If known Date of birth: 31031988

NHS N°†:

N.I.N°†:

Date of last sight test:

☐ First test ☒ Not known

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

ELIGIBILITY

(Optician use only) Evidence of eligibility ☒ Seen ☐ Not Seen

Tick all boxes which apply to you.

☒ I am 60 or over ☐ I am under 16 ††

☐ 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 †† at the school / college / university below:

☐ I am a prisoner on leave from the prison detailed below ††

I suffer from ☐ diabetes / ☐ glaucoma – my GP's details are below

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

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

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

Details of establishment (school / college / university / prison / GP / local authority / hospital)

Name: ESTABLISHMENT NAME

Town: TOWN NAME

☐ I / ☐ my partner, or person I am dependent on if I am under 20, receive(s) or is included in an award of:

☐ Income Support

☐ Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC

☐ Pension Credit Guarantee Credit

☐ 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

Person getting the benefit / credit if not the patient:

Name:

N.I.N°†:

Date of birth:

☐ I am named on a valid HC2 certificate ††

Certificate number: HC2 -

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

Part 2 PATIENT'S DECLARATION

** *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 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 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 to NHS Business Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, 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: 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.

I am the ☐ patient ☒ patient's parent ☐ patient's carer or guardian

☒ same address as patient

Signature**: Sign

Date: 31032021

Name: FIRSTNAME SURNAME

Address: ADDRESS

Postcode: LS11 0PA

I -

P -

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Tips for Completing Paper GOS 6 forms

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

NHS England

Primary Care Support England

A cross should be placed against the patient's ethnic group if they wish to complete this section.

You must enter the date the sight test took place in the format DDMMYYY.

Record an early retest code if applicable. Use code 1, 2 and 6. NOT 1.0, 2.0 and 6.0.

Cross (✗) 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.

If a voucher was issued enter the relevant voucher category as to whether the patient is receiving distance/bifocals or whether they are receiving a reading voucher.

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.

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.

Cross (✗) to claim the sight test fee and the appropriate domiciliary fee.

Enter the address and postcode where the sight test took place. Please ensure this matches what you entered on the PVN.

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

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 Caribbean	☐ Asian or Asian British Indian	☐ Black or Black British Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Asian or Asian British Pakistani	☐ Black or Black British African	☐ Any other ethnic group
☐ Any other White background	☐ White and Asian	☐ Asian or Asian British Bangladeshi	☐ Any other Black background	☐ Not stated
	☐ Any other mixed background	☐ Any other Asian background		

Part 3 PERFORMER'S DECLARATION

I have tested the sight of the person named on this form on: 31032021

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

☐ 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

The patient was the: ☒ 1st patient at the address ☐ 2nd patient at the address ☐ 3rd or subsequent patient at the address

☐ The patient was referred

☐ A statement was issued showing no prescription was required

☐ The patient was added/substituted on the day of the visit

☐ A new or changed prescription was issued

☒ An unchanged prescription was issued

☐ A voucher was issued:

Distance/ Bifocal voucher type: ☐ or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

Reading voucher type: ☐ or / ☐ Complex **Supplements:** ☐ Prism ☐ Tint

☒ If the sight test has been conducted by the contractor only one signature is required at the bottom of this form. Please put a cross in the box and complete the performers name and performer list number only.

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

Performer's name: FIRSTNAME SURNAME

Performers list number: 01-99999

Performer's signature: Sign

Date: 31032021

CLAIM

I claim:

☒ the current NHS sight test fee

☒ the domiciliary fee for the 1st or 2nd patient at the address

☐ the domiciliary fee for the 3rd or subsequent patient at the address

Address where sight test took place: 123 STREET NAME

Postcode: LS11 0PA

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. 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: Sign

Date: 31032021

Name: FIRSTNAME SURNAME

Contractor's name: PRACTICE NAME

Organisation number: A1A1A

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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

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:

PCSE YouTube Channel

Search 'Paper GOS Claims'.

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

0333 014 2884

NHS England

Primary Care Support England