# 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 details, ensuring 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 do not 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 **(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.

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 **(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.

**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**

*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

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

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 ☐ Income-based Jobseeker's Allowance ☐ Universal Credit and meets the criteria. Find out more at www.nhsbsa.nhs.uk/UC ☐ Income-related Employment and Support Allowance ☐ Pension Credit Guarantee Credit ☐ Tax Credit and I am / we are named on a valid NHS Tax Credit Exemption Certificate

Person getting the benefit / credit if not the patient:

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 -

**This example uses a paper GOS6 form but the guidance applies to all claim types.**

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

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NHS England

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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 (**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

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 (**x**) 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 1 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: .

☐ 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: 31 03 2021

**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: 31 03 2021

Name: FIRSTNAME SURNAME

Contractor's name: PRACTICE NAME

Organisation number: A1A1A

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