



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

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 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 or HC3, 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 placed 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:

M R

First names:

F I R S T N A M E

Surname:

S U R N A M E

Previous surname*:

1 2 3 S T R E E T N A M E

Address:

T O W N

C I T Y

Postcode: L S 1 1 0 P A

Date of birth:

3 1 0 3 1 9 8 8

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:

☐ I am under 16

☒ 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:

E S T A B L I S H M E N T N A M E

Town:

T O W N N A M E

☒ 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

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

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 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:

3 1 0 3 2 0 2 1

Name:

F I R S T N A M E S U R N A M E

Address:

A D D R E S S

Postcode: L S 1 1 0 P A

Voucher code:

Authorisation code:



I -

P -

This example uses a paper GOS 3 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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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 Pair and Total in row 2.
- 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://odspportal.digital.nhs.uk/Organisation/Search>

Cross the type of glasses supplied

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 placed in the 'same address as patient' box where appropriate.

PRESCRIPTION

To be completed by the practitioner at your sight test

R L ADD Sph +/- Cyl +/- Axis Prism Base +/- Sph +/- Cyl +/- Axis Prism Base

+ 1 5 0 - 0 5 0 9 0 1 0 0 T 0 0 0 - 1 2 5 8 5

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

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

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

Performer's name: F I R S T N A M E S U R N A M E

Performers list number: 0 1 - 9 9 9 9 9

Date of this prescription: 3 1 0 3 2 0 2 1

Performer's signature: Sign

Date: 3 1 0 3 2 0 2 1

Part 3 SUPPLIER'S DECLARATION

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

In accordance with the prescription I have supplied: ☐ contact lenses ☒ glasses

The glasses/contact lenses I have supplied are: ☐ distance pair and / or ☐ near pair or ☒ bifocal / varifocal pair

☐ has an unchanged prescription but has glasses / contact lenses which are unserviceable due to fair wear and tear

☐ Exception Processing

Claim: Supplements provided:

*Please write the number of lenses

Pair: ☐ Prism ☐ Tint* ☐ Small Glasses* ☐ mm ☐ Special facial characteristics ☐ Prism controlled bifocals

Pair: ☐ Prism ☐ Tint* ☐ Small Glasses* ☐ mm ☐ Special facial characteristics

Claim under the NHS optical voucher scheme as follows:

	1 st pair	2 nd pair	Total
Actual retail cost of glasses / contact lenses	£ 0 0 0 . 0 0	£ 0 0 0 . 0 0	£ 0 0 0 . 0 0 (1)
If less than or equal to voucher value(s) plus any supplement(s)	£ 6 7 . 5 0	£ 0 0 0 . 0 0	£ 6 7 . 5 0 (2)
Total of voucher(s) and supplement(s) (specified above)	£ 6 7 . 5 0	£ 0 0 0 . 0 0	£ 6 7 . 5 0 (3)
Patient's contribution as shown by box B of HC3 (if applicable)			£ 0 0 0 . 0 0 (4)
Total claim for glasses / contact lenses (1 or 2 - whichever is the lowest, minus 3)			£ 6 7 . 5 0

DECLARATION

I claim 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/contract-us/privacy-notice/> or by contacting 0300 311 22 33.

Date of first / only pair supplied: 3 1 0 3 2 0 2 1

Date of second pair supplied: Supplier's signature: Sign

Name: F I R S T N A M E S U R N A M E

Supplier's name: P R A C T I C E N A M E

Organisation number: A 1 A 1 A

Part 4 PATIENT'S DECLARATION

"Please write the number of pairs of contact lenses you have received"

I confirm that I have received ☐ distance pair and / or ☐ near pair ☒ bifocal / varifocal pair of glasses or ☐ pairs of contact lenses, on the date shown above, and used an NHS optical voucher.

I agree that the declaration signed on Part 2 of this form also applies for the collection of my glasses/contact lenses. I agree that none of the information on this form has changed and I am still eligible. If I am not the same patient's parent or patients carer or guardian that signed Part 2

I confirm I have read the declaration as detailed in Part 2.

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

Signature: Sign

Date: 3 1 0 3 2 0 2 1

Name: F I R S T N A M E S U R N A M E

Address: Postcode:

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