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: First names:

Surname:

*If changed within the past 12 months

Previous surname*:

Address:

Postcode:

† If known

Date of birth: NHS N°†: N.I.N°†:

Date of last sight test: 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 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:

Town:

+ 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 ††ⁱ +

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

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.

** 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 patient's carer or guardian same address as patient

Signature**: Date:

Name:

Address:

Postcode:

I -

P -

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: ☐☐☐☐☐☐☐☐

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

☐ A statement was issued showing no prescription was required

☐ 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:

Performers list number:

Performer's signature:

Date:

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:

Date:

Name:

Contractor's name:

Organisation number: