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 -**

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

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

☐ 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

†† *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:

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

☐ 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**: 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 ☐.☐

☐ 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:

Performers list number:

Performer's signature:

Date:

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

Postcode:

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: