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:	First names:			
past 12 months	Surname:				
	Previous surname*:				
	Address:				
			Postcode:		
	Date of birth:	NHS N° †: N.I.	N ^{o †} :		
	Date of last sight test:	First test Not known			
	ELIGIBILITY				
	☐ I / ☐ my pa	rtner 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 a	ttend a practice unaccompanied for a sight test because:			
+	Please choose (ONE selection from the list to indicate your ethnic group (optional):			
	White	Mixed Asian or Asian British Black or Black Britis	3		
	British	White and Black Asian or Asian British Black or Black B Caribbean Indian Caribbean	British Chinese		
	Irish	White and Black Asian or Asian British Black or Black B African Pakistani African	Any other ethnic group		
	Any other Wh	nite White and Asian Asian or Asian British Any other Black	Not stated		
backgroui		Bangladeshi background Any other mixed Any other Asian			
		background background			
Part		PATIENT'S DECLARATION			
under 16 or		information I have given on this form is correct and complete. I understand that if it is not, apayment of the difference between my patient contribution and the NHS sight test fee and pay			
incapable of signing,		k my entitlement, and on the basis of NHS England performing tasks in the public interest, m s Services Authority, Department for Work and Pensions, HM Revenue & Customs, NHS Digi			
your parent, carer or	education provid	ers, HM Prison Service, local authorities, and bodies performing functions on their behalf. I m	nay also be contacted about this		
other person responsible	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				
for you should sign		ee to me doing so, and I will draw this notice to their attention. ent patient's parent patient's carer or guardian	same address as patient		
and give their name	. а а рас				
and address					
	Signature**:		Date:		
	Name:				
	Address:				
			Postcode:		



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raits	FERFORMIER 3 DECLARATION				
	ested the sight of the person In the case of a re-test at less than the standard interval, please specify the appropriate code:	d .			
T	e patient was referred A new or changed prescription was issued	d			
Па	statement was issued showing no prescription was required An unchanged prescription was issued				
	oucher was issued:				
Distan	e/ Bifocal voucher type: or / Complex Supplements: Prism Tint If the sight test has be contractor only one sign	peen conducted by the nature is required at the			
Readii	g voucher type: or / Complex Supplements: Prism Tint bottom of this form. Plea	ase put a cross in the box mers name and performer			
This pa	ient was the:				
1 st	atient at the address 2 nd patient at the address 3 rd or subsequent patient at the address				
	ompleted by the Performer who has conducted the sight test				
Perforr name: Perforr	ers — — — — — — — — — — — — — — — — — — —				
list nur	per:				
Perforr	er's				
signatu	e: Date:				
CLAIN I claim	for a sight test:				
Lower	f private charge or NHS sight test fee	£ (1)			
Lower	f the private charge or NHS domiciliary visit fee (where appropriate)	£ (2)			
Maxim	m claimable in respect of sight test (sum of 1+2)	£ (3)			
	s contribution as shown by box A of HC3	£ (4)			
Total c	nim in respect of sight test (3 minus 4)	£			
Addres	s where sight test took place				
	Postcode:				
DECL	RATION				
form is I withhor civil	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 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	To be completed by the contractor or authorised signatory				
Signati	re: Date:				
Name:					
Contra name:					



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