Claim Record

8	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
9	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
10	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
11	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
12	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
13	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
14	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature

* ENS = Evidence Not Seen

HSC Business Services Organisation

Providing support to Health and Social Care

Health Service Ophthalmic Form — OCSPR

Please fill in Part A and sign Part B, using capital letters throughout. If the patient is under 16 or cannot sign the form, someone else must sign it on their behalf.

PART A – PATIENT INFORMATION & DECLARATION:

Surname	
Forename	
Date of Birth	
Health & Care Number	

- **I understand** that if I knowingly give information that is false, action may be taken against me.
- **I declare** that the information I have given is correct and complete to the best of my knowledge.
- **I agree** to pay the cost of the sight test and/or spectacles if I am found not to qualify for help.
- **I apply** for a General Ophthalmic Services sight test and/or help with the cost of the spectacles for the reason I have ticked in Part B.

There is no insurance, warranty or other after sales care covering these spectacles. I consent to information relating to the General Ophthalmic Services provided to me being made available to other Departments / Agencies for Health and Social Care planning purposes and for the purpose of preventing or detecting fraud.

Signature	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	**Date**	_ _ / _ _ / _ _

- I am the patient. X
- **OR** I am signing on behalf of the patient (give details below). X

Name	_ _
Relationship to Patient	_ _

Optician Declaration - I declare that the information I have given on this form is, to the best of my knowledge, correct and complete and I understand that if it is not, action may be taken against me. For the purposes of verification of this claim, I consent to the disclosure of relevant information. I claim payment of the agreed GOS fees.

Practice Code	_ _ _ _

This form is to be retained in the practice unless requested by BSO or other authorised body.

PART B – I DO NOT HAVE TO PAY HS CHARGES BECAUSE:	
I am under 16 years of age.	X
I am a full time student aged 18 or under **AND** the name and address of the college I attend is: _	X
I am named on a valid HC2 certificate.	X
I am named on a valid HC3 certificate for: Part A - Sight Test Part B - Voucher	£ _____ £ _____
I am named on a valid NHS Tax Credit Exemption Certificate.	X
• I (or my partner) receive Income Support.	X
• I (or my partner) receive income-based Jobseeker's Allowance.	X
• I (or my partner) receive income-related Employment Support Allowance.	X
• I (or my partner) receive Pension Credit Guarantee Credit	X

Name of Benefit Recipient	Date of Birth	National Insurance Number
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	_ _ / _ _ / _ _	_ _ _ _ _ _ _ _ _

I qualify for a Health Service sight test/eye examination on the following grounds:

Over 60 years old	X	* I am at risk of glaucoma	X	I am registered blind or partially sighted	X
* Diabetic	X	* Aged 40+ and the parent/sister/brother/child of a glaucoma sufferer	X	I have been prescribed complex lenses as defined for the purpose of the Health Service voucher scheme	X
* Glaucoma	X				

Name and address of GP practice or hospital consultant:

_ _

_ _

* I give consent to the BSO to contact my GP practice regarding the claims made concerning Diabetes or Glaucoma.

Patients found to have wrongly claimed exemption from or help with health costs may face a penalty charge and in some cases prosecution. Routine checks are carried out on exemption claims and you may be contacted in the course of these checks.

Version: 1.3

Date: 01/04/2014

Claim Record

1	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
2	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
3	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
4	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
5	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
6	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature
7	Date		Claim ID		Patient Signature
	Sight Test X	Voucher X	Repair X	ENS* X	Optician Signature

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