In order to accept correctly filled GOS forms, we would remind you that all fields on any GOS forms you submit MUST be completed; particularly pay attention on the followings, failure to do so could result in payment to you being delayed.

1. Indicate the grounds under which form was issued;

	(GOS3/4)		
• Part 2 If your address has changed from that shown above write in your new one in	Patient's declaration My name and address are as shown above. I wish to order glasse 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 and attend:	es/contact lenses*	optician's use onsy envolution of seen
Part 4	School/College/University*:		
	Address:	Postcode:	
Tick any box which applies to you. These circumstances must apply on the date you order your glasses or contact lenses	Imy* partner receives         Income Support         Income based Jobseekers Allowance         Income-related Employment and Support Allowance         Person getting the benefit/credit* if not the patient:         Name:         I am named on a valid         HC2         HC3 (box B) shows that the voucher value will be refined and prisoner on leave from the prison detailed below         Prison:         Address:         I have been prescribed complex lenses under the NHS optimized to the prison of the prison	Postcode:	we are named on, a
	(GOS 1/6)		
Tick all boxes in Part 1	School/College/University*:	V	
that apply to you	Address:		
		Postcode:	
You may be entitled to			
an optical voucher if you are in one of these groups. Ask the	Income based Jobseekers Allowance <sup>†</sup> Income-related Employment and Support Allowance <sup>†</sup>	Pension Credit guarante ax Credit and I am/we ar NHS Tax Credit Exemption N.I.no :	e named on a valid
voucher if you are in one of these groups. Ask the person who	Income Support <sup>†</sup> Income based Jobseekers Allowance <sup>†</sup> Income-related Employment and Support Allowance <sup>†</sup> Person getting the benefit/credit <sup>*</sup> if not the patient:	ax Credit and I am/we ar NHS Tax Credit Exemption N.I.no*:	e named on a valid
voucher if you are in one of these groups. Ask the	Income Support <sup>†</sup> Income based Jobseekers Allowance <sup>†</sup> Income-related Employment and Support Allowance <sup>†</sup>	ax Credit and I am/we ar NHS Tax Credit Exemption	e named on a valid

- If the patient's age is over 60 they are ineligible for Income Support(GOS 3/4) unless they are providing evidence of Income Support.
- if patient's partner is on benefit please fill in beneficiary details including their date of birth and if possible their national insurance number;

Person getting the benefit/credit* if not the patient:	N.I.no":			
Name:	Date of birth:	1	1	

- If someone is in full time education (over 19) and is named on Tax Exemption Certificate of the parents, they will qualify for NHS funded sight test/voucher <u>only if they can provide proof</u>.
- 5. Indicate the number of form HC2/HC3.
- 6. Indicate the amount that the voucher is reduced by, if the patient holds form HC3
- if over 16 and in full time education, indicate the full name and address of the school/college attended

I am a full time s	tudent aged 16, 17 or 18 and attend:	/ //	Evidence not seen	
School/College/U	niversity*:			
Address:				
		Postcode:		

- 8. Complete all the date fields on the form(s).
- 9. The Date collected must be on or after Date Ordered
- Complete all the signature fields on the form(s).
   (Patient/Performer/Supplier/Contractor)
- 11. Indicate the patient's date of birth.
- 12. Indicate the patient's full address including postcode
- 13. Indicate the patient's full name (full first name we cannot accept initials)
- 14. Signature on the back of GOS1 (Contractor part) must match our record of authorised signatories.

Signatur	e:	*/	
Name: (in block ca	pitals):		
Date:	1	1	
Contract (where issue	tor numb	er	
Perform (if appropria	ers list nu ate):	mber	

15. The Suppliers/Performer/Practitioner declarations must be filled in

	GOS 3
Performer's name: (print)	Performers list no:
Signature:	Date: / /
	GOS 1
To be completed by the Perfo	ner who has conducted the sight test
Performer's signature:	
Performer's name: (in block capitals)	
Performers list number:	
Date: / /	

16. If payment address is different to the practice address, please indicate on the back of the form.

Practice address where sight test took place: (in capitals/stamp)	Address (if different) where payment should be sent: (in capitals/stamp)

- 17. We do not pay domiciliary fees for sight test carried out at day centres/walk in centres, please verify before booking someone, also we cannot process any domiciliary claims for sight test carried out of area i.e. if you got a contract to carry out domiciliary sight tests in Birmingham and you submit a claim for someone living in Solihull, we will not process that claim unless you also got a contract for Solihull Area.
- 18. Indicate on the back of GOS 6 form if 1<sup>st</sup>/2<sup>nd</sup>/3<sup>rd</sup> or subsequent patient at the address.

/	I have made a domi	ciliary visit to conduct this s	ight test to one pa	tient at the addr	ess in Part 1				
1	I have made a domiciliary visit to several patients at the address in Part 1								
	This patient was the:								
	1st patient at the address								
	2nd patient at the address								
	3rd or subse	quent patient at the addres	is 🥖						
/	The patient was refe	erred to their GP or Ophtha	Imic hospital						
1	A statement was iss	ued and no prescription was	s required						
1	An unchanged press	cription was issued							
1	A new or changed p	prescription was issued							
/	A voucher was issue	d:	11						
First vo	oucher type:	Supplements:	Complex	Prism 🗸	Tint				
Second	l voucher type:	Supplements:	Complex 🗸	Prism	Tint				
To be comple	ted by the performe	r who has conducted the	sight test		1				
Performer's si	gnature:								
Performer's na	ame: (in block capitals)		Da	te:	1				
Performers Lis	st number:								
I claim:									
	rrent NHS sight test fe	e	£						
	miciliary fee for:								
	1st patient at the ad		f		_				
	2nd patient at the a		£		-				
	3rd or subsequent pa		£		-				
	Total claim for sight	test	f						

19. For adult repairs (GOS 4), please get *authorisation code* from shared services by ringing 0121 465 1025, and write that code on part 3, without that code we cannot process your claim.

Part 3	To be completed by the Primary Care Trust	
	The applicant's claim has been considered and is: approved    not approved	PCT name and address: (stamp or write in capitals)
	Full name:	
	Signature:	Date: / /

20. Always explain how the loss or damage happened on GOS 4 before submitting your claim to us.

I have explained below<sup>†</sup> how the loss or damage happened.

21. Indicate what voucher type you are claiming on the back of GOS 3/4 including amount claimed. We also need full prescription on GOS 3 and GOS 4.

R	Sph	Cyl	Axis	Prism	Base		Sph	Cyl	Axis	Prism	Base
G						Distance	1				
H T						Near		V			
						1 100	- Annual and		-		
	CLAIM	Sector Sec.				heme as follow			1st pair		2nd pair
						ct lenses* if les any supplemer			£	+	£
			oucher val		and the former of	- J seppression		f	11	f	-
			1:	st pair		2nd p	bair			-	
		(3)	<ul> <li>Co</li> </ul>	mplex		<ul> <li>Compl</li> </ul>	ex	£		£	0
		Supplement(s)	V Pr	ism		Prism		£		£	(4
		opler	< Tir	The second states		✓ Tint		£		£	(!
	<sup>1</sup> Please state boxed centre	Sup	1	Small glass	ies <sup>†</sup>	✓ Sm	all glasses <sup>†</sup>	£		£	(
	distance in millimetres	٢	otal of vou	cher(s) and	suppleme	nt(s) (sum of 2,3,4	,5+6)		£	+	£
		Т	he cost of	the glasses of	or contact	lenses exceeds	(7) for the		1st pair	r 🔽	2nd pai
		N	Aaximum c	aimable for	glasses/co	ontact lenses*	Nower of 1 or 7	7)	£	17	
		F	atient's con	ntribution a	s shown by	y box B of HC3	(if applicable,		£	11	
		٦	otal claim f	or glasses/c	ontact len	ses* (8 minus 9)			£	7	
						GOS 4					
						6054					
R	Sph	Cyl	Axis	Prism	Base	E. Color	Sph	Cyl	Axis	Prism	Base
l G					14	Distance				277	

Voucher type:	Supplements:	Complex	<ul> <li>Pris</li> </ul>	m 🗸 🗸	Tint	
Voucher value appropria	ite to the above presc	ription		£	(1)	
Parts: Lens/C.L*	🗸 🥖 Right 🛛 🗸	Left	Bot	h £	(2)	
Frame	Front	Side	Wh	ole £	(3)	
Supplements:	Complex			£	(4)	
11	✓ Prism			£	(5)	
	✓ Tint			£	(6)	
	Small glasses			£	(7)	
I claim under the NHS or	otical voucher scheme:					
Voucher value plu	s any supplement(s) (s	um of 1+(4+5+6+	+7))	£	(8)	
or part(s) at current p	or part(s) at current prices plus any supplement(s) (sum of (2+3)+(4+5+6+7))					
or actual retail cost, i	£	(10)				
Patient's contribut	e) £	(11)				
Total claim (8 or 9	or 10 - whichever is the	lowest, minus 1	1)	£		