GOS_3-Sep08.qxp 16/10/08 14:47 Page 1

GOS 3 NHS optical voucher and patient's statement

To get your glasses/contact lenses, fill in, sign and date Part 2 when you order them from the optician of your choice. Sign and date Part 4 overleaf to confirm that you have received them.

Please complete this form using black ink and in block capitals

Part 1 Patient's details

* delete as appropriate

Mr/Mrs/ Miss/Ms*: Surname:

Previous surname: (If changed within the past 12 months)

First names:

Date of birth: / /

Address:

Date of prescription must be completed. dd/mm/yy

Postcode:

\# if known

Date of this prescription: / /

NHS no#:

N.I.no#:

To be completed by the practitioner at your sight test

First voucher type: Supplements: ✓ Complex ✓ Prism ✓ Tint

Second voucher type: Supplements: ✓ Complex ✓ Prism ✓ Tint

RIGHT Sph	Cyl	Axis	Prism	Base		LEFT Sph	Cyl	Axis	Prism	Base
					Distance					
					Near					

Primary Care Trust receiving relevant GOS1 or GOS 6† :

† if applicable

Performer's name: (print)

Performers list no:

Signature:

Date: / /

Part 2 Patient's declaration

If your address has changed from that shown above write in your new one in Part 4

My name and address are as shown above. I wish to order glasses/contact lenses* and I am entitled to use the above voucher today because:

Optician's use only

Evidence not seen

✓ I am under 16

✓ I am a full time student aged 16, 17 or 18 and attend:

School/College/University*:

Address:

Postcode:

Tick any box which applies. These circumstances must apply on the day you order your glasses or contact lenses

At least one eligibility criteria must be ticked to indicate why an NHS test is being claimed.

I/my* partner receives

✓ Income Support

✓ Income based Jobseekers Allowance

✓ Income-related Employment and Support Allowance

✓ Pension Credit guarantee credit

✓ 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:

N.I.no#:

Name:

Date of birth: / /

I am named on a valid ✓ HC2 ✓ HC3 certificate, number:

The HC3 **(box B)** shows that the voucher value will be reduced by: £

If the patient has an HC3, the value must be entered here.

✓ I am a prisoner on leave from the prison detailed below:

Prison:

Address:

Postcode:

✓ I have been prescribed complex lenses under the NHS optical voucher scheme

DECLARATION

I declare that the information given on this form is correct and complete, I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and or civil proceedings. I confirm I am entitled to an NHS optical voucher and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud. I agree to repay the voucher value if I am later found not to be entitled to it.

I am the ✓ patient ✓ patient's parent, carer or guardian.

One of these boxes must be checked.

** 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

Signature**:

Date: / /

Name: *(in block capitals)*

Address: *(if different from above)*

If the form is signed by a parent, carer or guardian they must print their name. If the parent, carer or guardian's address is different to the patient then they must also print their address

Postcode:

NHS

Part 3 Supplier's declaration

In accordance with the prescription overleaf I have supplied:

Either glasses or contact lenses must be checked.

✓ glasses or ✓ contact lenses because the patient named on this optical voucher:

✓ requires a new or changed prescription

✓ has an unchanged prescription but has glasses/contact lenses* which are unserviceable due to fair wear and tear

Either new prescription or fair wear and tear must be ticked.

CLAIM

I claim under the NHS optical voucher scheme as follows:

Actual retail cost of glasses/contact lenses* if less than or equal to voucher value + supplement(s)

Supplement must match the value entered in part 1

Voucher value(s)

Supplement(s)	1st pair	2nd pair
	✓ Complex	✓ Complex
	✓ Prism	✓ Prism
	✓ Tint	✓ Tint
	✓ Small glasses†	✓ Small glasses†

† Please state boxed centre distance in millimetres

	1st pair	2nd pair	
	£	£	(1)
	£	£	(2)
	£	£	(3)
	£	£	(4)
	£	£	(5)
	£	£	(6)
Total of voucher(s) and supplement(s) *(sum of 2,3,4,5+6)*	£	+ £	(7)

Claims must have a value in either (1) or (2)

If supplements are being claimed values must be entered.

The cost of the glasses or contact lenses exceeds (7) for the ✓ 1st pair ✓ 2nd pair

Maximum claimable for glasses/contact lenses* *(lower of 1 or 7)*	£	(8)
Patient's contribution as shown by **box B** of HC3 *(if applicable)*	£	(9)
Total claim for glasses/contact lenses* *(8 minus 9)*	£	

It isn't acceptable to enter a total claim value without completing the other boxes as required.

DECLARATION

I claim the payment shown above under the NHS (Optical Charges and Payments) Regulations [illegible] that the information given on this form is correct and complete and that this is the original form submitted by me or the patient, or other person as appropriate. I understand and accept 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 or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of the claim and in relation to the prevention and detection of fraud.

Supplier's signature:	Supplier's name and address: *(in capitals/stamp)*
Date of first/only pair supplied: / /	
Date of second pair supplied: / /	

Part 4 Patient's declaration

† Please write the number of pairs of contact lenses you have received in this box

I confirm that I have received *(tick as appropriate)*; one pair ✓ or two pairs ✓ of glasses

or † ☐ pairs of contact lenses, on the date shown above and used an NHS optical voucher.

One of these boxes must be checked.

I declare that the information overleaf which entitles me to [illegible] is correct and complete. I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and or civil proceedings

** 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, carer or guardian.

Signature**:	Date: / /
Name: *(in block capitals)*	
Address: *(if different from overleaf)*	

Date of patient signature must be the date of collection of second pair as stated in the supplier's declaration if two pairs have been supplied or date of collection of first pair if only one pair has been supplied