

# GENERAL OPHTHALMIC SERVICES (GOS) PATIENT DECLARATION FORM

The form is utilised by providers of NHS funded sight tests and optical vouchers when the electronic system is unavailable. The form will be stored by the provider for validation purposes, adhering to the NHS privacy notice for processing personal data. Fields marked with an asterisk are optional.

## CLAIM DETAILS

Claim form type      GOS 1       GOS 3       GOS 4       GOS 5       GOS 6

Claim ID\* \_\_\_\_\_

## PATIENT'S DETAILS

Title \_\_\_\_\_ First names \_\_\_\_\_

Surname \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Date of birth \_\_\_\_\_ NHS No\* \_\_\_\_\_ N.I.N.\* \_\_\_\_\_

## ELIGIBILITY

Eligible      Yes

Eligibility category \_\_\_\_\_

Evidence of eligibility      Seen       Not seen

## PATIENT'S DECLARATION

NHS Sight Test (tick if applicable)       NHS Optical Voucher - Issue (tick if applicable)

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/cost of the optical vouchers and payment of a penalty charge. For repairs/replacements, I confirm that the full cost of replacement or repair cannot be met under the terms of any warranty, insurance or other arrangement. 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 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 or another person, they agree to me doing so, and I will draw this notice to their attention.

NHS Optical Voucher - Collection (tick if applicable)

I confirm that my distance pair  near pair  bifocal / varifocal pair  of glasses / contact lenses have been:

Collected       Repaired       Replaced

I am the patient  patient's parent  patient's carer or guardian  same address as patient

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_