

		OCSPR Form (v2.0) Ophthalmic Claim System Patient Record	
This form is to be retained in the practice as per regulations unless requested by an authorised body. Please contact BSO if this form is required in an alternative accessible format.			
PART 1 – PATIENT INFORMATION			
Surname		Forename	
Health & Care No.		Date of Birth	
General Ophthalmic Services (GOS)			
<ul style="list-style-type: none"> Please complete this form using block capital letters and black ink only. The optometrist / optician or practice staff should complete Parts 1 and 2. The patient must read Parts 3 and 4. Further information should be recorded in Part 4 if relevant. If the patient is under the age of 16 or unable to complete the form personally for any reason, a representative must read and sign this form on their behalf and must note their relationship in the relevant field. 			
PART 2 - PRACTICE INFORMATION		Practice Name	
Practice Code			
PART 3 – PATIENT DECLARATION			
By signing my name against any claims attached to this form, I agree that:			
a) I declare that the information I give on this form is correct and complete.			
b) I understand that if it is not, appropriate action may be taken, including recovery of charges.			
c) I apply for a General Ophthalmic Services sight test and/or help with the cost of the spectacles or contact lenses for the reason I have outlined in Part 5.			
d) I agree to pay the cost of the sight test and/or spectacles if I am found not to qualify for help.			
e) I understand there is no insurance, warranty or other after sales care covering any spectacles or contact lenses provided.			
f) I confirm proper entitlement to exemption or remission.			
g) I consent to the use of this information for the management of healthcare services, to enable HSC Business Services Organisation (BSO) to check I have a valid exemption/remission and for the purposes of prevention, detection and investigation of fraud and incorrectness.			
h) I consent to the disclosure of relevant information from this form including to and by: the Business Services Organisation; Health and Social Care Board; the Department of Health; the Department for Work & Pensions; Social Security Agency; HM Revenue & Customs; NHS Counter Fraud & Security Management Service; or any other authorised body.			
i) I confirm that, immediately following my sight test, I have been given form GOS(NI)P which indicates the prescription for any spectacles or contact lenses which I require, or a statement confirming the results of the Sight Test.			

PART 4 – EXEMPTION CATEGORY CODES & PATIENT EXEMPTION DETAILS					
The following Exemption Category Codes must be used when completing Part 5:					
A	Child / Over 60	H	Income Support **	N Person with Glaucoma	
B	Full-time student (aged 18 or under) *	I	Pension Credit Guarantee Credit (PCGC) **	O Person at risk of Glaucoma	
C	Income-based Employment Support Allowance **	J	Income-based Job Seeker's Allowance (JSA) **	P Aged 40+ and a relative of a person with Glaucoma	
U	Relevant Universal Credit Recipient	L	HC3 Partial-Help Certificate ***	Q Person with Diabetes	
G	HC2 Full-Help Certificate	M	Complex lenses	R Person certified as blind or partially sighted	
Please fill out any supporting information required for Exemption Categories B, C, H, I, J and L in the relevant section(s) below:					
* Name and Address of School or College					
** Details of the benefit recipient (either the patient or their partner) to be entered below:					
Name of Benefit Recipient					
Date of Birth		National Insurance No.			
*** Please enter values from HC3 Certificate:		Part A – Sight Test	£ ____ . ____	Part B – Voucher	£ ____ . ____
Explanatory notes for PART 5 – PATIENT GOS CLAIM RECORD					
The optician or their practice staff must complete sections a. Claim ID and b. Claim Type [S/V/R] , where S = GOS Sight Test, V = GOS Voucher and R = GOS Repair or Replacement.					
The patient or their representative must read Parts 3 and 4 on this form, then complete sections c. Exemption Category Code , d. Date and e. Signature of Patient . If the patient is under the age of 16 or unable to sign the form personally, these fields can be signed on their behalf by a suitable representative who must then complete section f. Relationship to Patient . They should sign and date row "1" to confirm entitlement to a GOS Sight Test, then row "2" to confirm receipt of the GOS(NI)P prescription / statement from that test. For GOS Voucher or GOS Repair / Replacement claims, they should sign and date row "1" when ordering the spectacles or contact lenses, then row "2" upon collection.					
Sections g. Signature of OMP / Optometrist / Prescriber / Supplier and h. OO/OMP Code must be signed by the relevant individual. For a Sight Test claim only a Prescriber's signature is required. For Voucher and Repair / Replacement claims, a Prescriber's signature is required when the appliance(s) are prescribed and a Supplier's signature is required upon supply.					

