HSC Business Services Organisation

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)

- 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 Code		**Practice Name**	

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
E	Tax Credit Exemption Certificate	**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.

PART 5 – PATIENT GOS CLAIM RECORD

a. Claim ID	b. Claim Type [S / V / R]	c. Exemption Category Code		d. Date	e. Signature of Patient (or on patient's behalf)	f. Relationship to Patient (if applicable)	g. Signature of OMP / Optometrist / Prescriber / Supplier	h. OO / OMP Code
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