SCOTTISH EXECUTIVE

Health Department
Directorate of Service Policy and Planning

Primary Care Division
St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

10 September 2004

Dear Colleague

INTRODUCTION OF NEW HES FORMS

Summary

1. This letter advises NHS Boards, Hospital Eye Service (HES) departments and Practitioner Services of the introduction of new HES forms with effect from 1 November 2004.

Background

2. HES forms are processed for payment by Practitioner Services (Ophthalmics) of NHS National Services Scotland. It is therefore important that the forms used by all HES departments in Scotland are standard. It is also vital for probity purposes that the forms contain up-to-date eligibility categories. To ensure consistency and accuracy of content it has been decided that HES forms will no longer be produced locally but will in future be produced, and kept up-to-date, centrally.

3. Stores of the new forms will be retained by Banner Business Supplies, Unit 2, Kingsthorne Park, Nettlehill Road, Houston Industrial Estate, Livingston, EH54 5DB and issued to HES departments on request.

4. Guidance on completion of the new forms, which follow the format of the GOS forms which have been in use since 1998, is contained in the Annex to this letter.

5. Stocks of current HES forms can be used until 1 November 2004 when remaining stocks should be destroyed.

Action

6. Chief Executives of NHS Boards are asked to ensure that this letter is brought to the attention of all staff concerned with the HES.

Addresses

For action
Chief Executives, NHS Boards

Hospital Eye Services Departments

For information
Chief Executive,
State Hospital Board for Scotland

Chief Executive,
NHS National Services Scotland

Director, Practitioner Services

Head,
NHSScotland Counter Fraud Services

Enquiries to:

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7. HES departments are asked to:

7.1 ensure that stocks of current HES forms are destroyed on 1 November 2004 and not used after this date;

7.2. order supplies of the new HES forms from Banner Business Supplies, at the above address, for use with effect from 1 November 2004;

7.3 order further supplies of HES forms from Banner Business Supplies as and when required – these forms are not to be copied locally.

Yours sincerely

DR HAMISH WILSON
Head of Primary Care Division

ANNEX

GUIDANCE ON COMPLETION OF NEW HES FORMS

1. Guidance on completion of the new HES forms is provided below. Copies of the new forms, which also contain instructions on how to complete them, are attached in black and white. The new forms will be predominantly white with a coloured band to identify the different type of form.

HES(S)(R1) Application for NHS sight test – referral from the Hospital Eye Service

2. This form should only be used to refer a patient to an optometrist or ophthalmic medical practitioner where the patient requires a sight test as a necessary part of the management of their eye condition and where the patient would not otherwise be entitled to a free NHS sight test. A list of those patients entitled to a free NHS sight test, and for whom this form should not be used, is contained on the form.

3. Part 1. Complete the patient's details – surname, forename, address, previous surname, where appropriate, and postcode in BLOCK LETTERS or attach patient details sticker. Enter date of birth and hospital registration number. Enter "x" in appropriate box to indicate whether the patient is male or female. The same information requires to be entered on forms HES(S)(P)2, HES(S)3 and HES(S)(R).

4. Part 1. Date of last NHS sight test field. Enter date of last NHS sight test. If this is not know enter approximate month and year. If this is the first NHS sight test which the patient is receiving leave blank. This information is also required on form HES(S)(P)2.

5. Part 1. The eye clinician referring the patient for a sight test should sign and date the form, print their name and complete the hospital details.

6. Part 2 of the form should be completed by the patient, or their representative, when they attend the optometrist/ophthalmic medical practitioner for a sight test.

7. Part 3 and Part 4 of the form should be completed by the optometrist/ophthalmic medical practitioner undertaking the sight test.

HES(S)(P)2 Patient's optical prescription or statement

8. Part 2 includes details of a prescription or statement. The prescriber should indicate the outcome of the test by entering "x" in the appropriate box. Any prescription details should also be entered.

9. The voucher and supplement field has been split to indicate whether the voucher issued, and any associated supplement(s), is for distance or near vision. For the voucher field you should enter the voucher letter code in the appropriate box(es) as per the following examples:

- where an A voucher is issued for distance enter "A" in the first box, which is marked D;

- where an A voucher is issued for near vision enter “A” in the second box, which is marked N;

- where a voucher issued for both distance and near vision enter the appropriate voucher letter code in each box;

- where bifocals are issued enter the appropriate voucher letter code in the first box.

This information is also required on form HES(S)3.

10. Where supplements are prescribed enter “x” in the appropriate boxes, eg where a tint is prescribed for distance vision enter “x” in the first box, where a tint is prescribed for near vision enter “x” in the second box, where a tint is prescribed for both distance and near enter “x” in both boxes. Where supplements are prescribed for bifocals enter “x” in the first box of the appropriate supplement(s). This is also on form HES(S)3.

11. Prescription. The prescription should be completed in the normal way. Fill in other relevant details, eg BVD. This information is also required on form HES(S)3.

12. The prescriber should sign and date the form and add the hospital stamp.

HES(S)3 NHS optical voucher and patient’s statement

13. NHS Hospital Eye Service Optical Voucher, date of sight test field. Enter the date of the sight test to which the voucher relates. This information is also required on form HES(S)(R).

14. Reason for issue field. The prescriber should give the reason for issuing the voucher by entering “x” in the appropriate box.

15. The prescriber should sign and date the form, print their name and add the hospital stamp.

16. Part 1 of the form should be completed by the patient, or their representative, when they order their glasses/contact lenses. Part 2 of the form should be completed by the patient, or their representative, when they collect their glasses/contact lenses.

17. Part 3 of the form should be completed by the supplier who dispensed the glasses/contact lenses.

HES(S)(R) HES optical repair/replacement voucher application form

18. Patient’s surname, forename, etc to be completed as other forms.

19. The patient’s eligibility category and Part 2 of the form should be completed by the patient, or their representative, when they order the repair to/replacement glasses/contact lenses. Part 3 should be completed by the patient, or their representative, when they collect their repaired/replacement glasses/contact lenses.

20. Part 4 of the form should be completed by the supplier who dispenses the repaired/replacement glasses/contact lenses.

HES(S)(R1) Application for NHS sight test – referral from the Hospital Eye Service

Fill in Part 1 and sign and date Part 2A. Once you have received your prescription/statement, you will be asked to sign and date Part 2B to confirm this. If the patient is under 16 years or incapable of signing, their parent, carer or other person in charge of them must sign.

Part 1 PLEASE USE BLACK INK AND BLOCK CAPITALS **PATIENT'S DETAILS**

Enter Surname, Forename, Address and Postcode in BLOCK LETTERS or attach patient details sticker

Enter only if patient has changed name since last visit

Give details we ask for

SURNAME .....

FORENAME .....

ADDRESS .....

POSTCODE .....

PREVIOUS SURNAME .....

D.O.B. .....

Enter date of birth

MALE [X] FEMALE [X]

Enter "x" in appropriate box

PATIENT IDENTIFIER (for CSA use) [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Leave blank

DATE OF LAST NHS SIGHT TEST ../../..

Enter date of last NHS sight test

HOSPITAL REGISTRATION NO .....

Enter hospital registration number

To be completed by Hospital Eye Service UNLESS THE PATIENT FALLS INTO ONE OF THE FOLLOWING CATEGORIES

To be completed only in respect of patients who would not in other circumstances be eligible for an NHS sight test. The patients that this form should not be used for are as follows:

- The patient is under 16
- The patient is a full time student aged 16, 17 or 18
- Where the patient or their partner receive:
  - Income Support
  - Income-based Jobseeker's Allowance
  - Pension Credit guarantee credit
- The patient, or their partner, is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
- The patient is registered blind/partially sighted
- The patient suffers from diabetes or glaucoma
- The patient requires complex lenses
- The patient is aged 60 or over
- The patient, or their partner, have an HC2 certificate
- The patient is considered to be at risk of developing glaucoma
- The patient is aged 40 or over and is the parent/brother/sister/child of a person with glaucoma

Eye Clinician to sign and date

Enter Eye Clinician's name in BLOCK LETTERS

Enter hospital name and address in BLOCK LETTERS

I am referring this HES patient for sight testing as part of the management of his/her eye condition

Eye Clinician's Signature ..... Date: ../../..

Eye Clinician's Name (print) .....

Hospital Name

Address:

Hospital stamp

Add hospital stamp

Part 2 **PATIENT'S DECLARATION**

A I declare that I am not eligible for an NHS sight test except by reason of this referral and I do not fall into any of the categories eligible for an NHS sight test set out in Part 1. I declare that the information I have given on this form is correct and complete and I understand that if it is not appropriate action may be taken.

To be completed by patient/ parent/guardian/ carer when patient attends for sight test

*[X] I have had a sight test at the place where I normally reside because I cannot leave there unaccompanied.

[X] I am the patient [X] I am the patient's parent, guardian or carer

Signature: ..... Date: ../../..

Name (if not the patient) .....

Address (if different to above) .....

..... Postcode .....

*Cross if appropriate

HES(S)(R1) **PRACTITIONER'S DECLARATION** **B**

To be completed by patient/ parent/guardian/ carer after sight test

B I confirm that I have received a prescription/statement. Please sign here once you have had your sight test.

Signature: ..... Date: ...../...../.....

Part 3

☒ I have tested the sight of the person named on this form on (*date*) D D – M M – Y Y Y Y

☒ I have made a domiciliary visit to conduct the sight test of this patient at the address in Part 1

This patient was unable to attend the practice for his/her sight test because:

Reason

To be completed by optometrist/ OMP who undertakes sight test

Part 4

☒ Statement issued

☒ No change in prescription

☒ A new or changed prescription was issued

☒ Non-tolerance voucher was issued: Type: D N

Supplement: D N *Complex* D N *Prism* D N *Tint*

I claim:

	£	P
☒ the NHS sight test fee		
☒ the domiciliary visiting fee for 1 patient:		

Total of claim for sight test £ –

Note

Remarks (eg non-tolerance, retest advised)

I declare that the information I have given on this form is correct and complete and I understand that if it is not action may be taken against me. I claim payment of fees due to me for work carried out on behalf of the Hospital Eye Service.

Practitioner's signature:

Date: D D M M Y Y Y Y

Ophthalmic list number:

Payment location code:

Practitioner's stamp

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HES(S)(P)2 Patient's optical prescription or statement (TO BE COMPLETED IN BLACK INK)

This form is your prescription following your sight test. If your sight test showed that you did not need a prescription, it states this too. If you need new glasses or contact lenses, show this prescription to the optician when you order them. A prescription is valid for two years, so keep this form in a safe place.

Part 1 PATIENT'S DETAILS

Enter Surname, Forename, Address and Postcode in BLOCK LETTERS or attach patient details sticker

SURNAME .....

FORENAME .....

ADDRESS .....

.....

POSTCODE .....

Enter only if patient has changed name since last visit

PREVIOUS SURNAME .....

D.O.B. .....

Enter date of birth

MALE [ ] FEMALE [X]

Enter "x" in appropriate box

Enter date of last NHS sight test

DATE OF LAST NHS SIGHT TEST ...../...../.....

Enter hospital registration number

HOSPITAL REGISTRATION NO .....

Part 2 PRESCRIPTION OR STATEMENT

If the patient has a sight test, the Hospital should issue a prescription or statement to the patient.

I tested the sight of the above patient today and:

Enter "x" in appropriate box

- [X] No prescription was issued because this patient does not need glasses or contact lenses
- [X] Unchanged prescription
- [X] A prescription was issued
- [X] Non-tolerance case

Enter "x" in appropriate box(es) to show if supplement(s) prescribed

Enter voucher type in appropriate box

Voucher type: [D] [N] Supplements: [D] [N] *Complex* [D] [N] *Prism* [D] [N] *Tint*

Enter prescription

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

Any other relevant details:

Enter relevant details

Prescriber to sign and date

Prescriber's signature:

Date: ...../...../.....

Hospital Name and Address (block letters or stamp)

Add hospital stamp

Part 3 PATIENT'S INFORMATION

You may be entitled to help with the cost of your glasses or contact lenses through the NHS optical voucher scheme. Ask the person who tests your sight to give you a voucher.

WHERE TO GET YOUR GLASSES OR CONTACT LENSES

You can have this prescription dispensed by an optician of your choice, but not all opticians can supply contact lenses. Unregistered suppliers cannot sell glasses to anyone under 16 or anyone registered blind or partially sighted. Unregistered suppliers cannot sell contact lenses.

ABOUT THE NHS OPTICAL VOUCHER

If you are in one of the groups below when you order your glasses or contact lenses, fill in part 1 of the voucher form you were given when you had your sight test and give it to the optician. If you have a certificate HC2 or HC3 show it to your optician. If you were not entitled to a voucher when you had your sight test but your circumstances change by the time you order your glasses or contact lenses, you can ask the optician who is to supply your glasses or contact lenses for a voucher. If they do not have vouchers, you can go back to the Hospital Eye Department that tested your sight and ask for a voucher before you order your glasses or contact lenses.

YOUR ENTITLEMENT TO HELP

You are entitled to the full value of a voucher **if, at the time you order** your glasses or contact lenses:

- you are under 16
- you are aged 16, 17 or 18 in full-time education
- you or your partner (if you have one) are getting:
  - Income Support
  - Income-based Jobseeker's Allowance
  - Pension Credit guarantee credit
  - The patient, or their partner, is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
- you or your partner (if you have one) hold an HC2 certificate for full help

If you are not in one of the groups above, but you were prescribed complex lenses, you are also entitled to some help.

If you were given a voucher when you had your sight test but your circumstances change before you order your glasses/contact lenses, you cannot use your voucher unless you are still in one of the above groups when you order your glasses/contact lenses.

You may be entitled to some help if you or your partner (if you have one) hold an HC3 certificate. The value of your voucher will be reduced by the amount shown on the certificate.

THE VALUE OF YOUR NHS OPTICAL VOUCHER

The value of your voucher depends on your prescription and will match a letter from A to J, plus supplements. Your optician has marked the letter and supplements (if any) on this form and the voucher form and can tell you the current values. Voucher values and supplements are also listed in leaflet HC12 *"NHS charges and optical voucher values"*. Ask your optician for a copy or get one from a Jobcentre Plus or main Post Office.

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HES(S)3 NHS optical voucher and patient's statement

To get your glasses/contact lenses, fill in, sign and date Part 1 when you order them from the optician of your choice. Sign and date Part 2 overleaf to confirm that you have received your glasses/contact lenses.

PLEASE USE BLACK INK AND BLOCK CAPITALS **NHS HOSPITAL EYE SERVICE OPTICAL VOUCHER**

To be completed by the practitioner who has tested your sight

SURNAME .....

FORENAME .....

ADDRESS .....

..... POSTCODE .....

D.O.B. .....

MALE ☒ FEMALE ☒

PATIENT IDENTIFIER (for CSA use) ☐☐☐☐☐☐☐☐☐☐

DATE OF SIGHT TEST ...../...../.....

PREVIOUS SURNAME ..... HOSPITAL REGISTRATION NO .....

Voucher type: D ☐ N ☐ Supplements: D ☐ N ☐ *Complex* D ☐ N ☐ *Prism* D ☐ N ☐ *Tint* D ☐ N ☐ *Special Facial Characteristics*

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

Any other relevant details (e.g. BVD):

Reasons for issue

☒ requires a new prescription ☒ requires a changed prescription ☒ non-tolerance case

☒ has no change in prescription but has glasses which are unserviceable through fair wear and tear

Prescriber's name *(print)*

Signature

Date: ...../...../.....

Hospital stamp

Part 1 PATIENT'S DECLARATION

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:

Cross the box which applies to you when you order your glasses/ lenses

☒ The patient is under 16

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

Name of School/College/University .....

Address .....

..... POSTCODE .....

These circum-stances must apply on the date you order your glasses or contact lenses

I/my partner receive(s):

☒ Income Support†

☒ Income-based Jobseeker's Allowance

☒ Pension Credit guarantee credit

☒ The patient, or their partner, is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate

Name of person getting the benefit/Credit if not the patient:

..... D.O.B. ...../...../.....

☒ I/my partner have an HC2 certificate No .....

☒ I/my partner have an HC3 certificate No .....

- which shows by **box B** the value of the voucher will be reduced by £.....

☒ I have been prescribed complex lenses as defined for the purposes of the NHS voucher scheme

☒ I am considered to be a non-tolerance case.

I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to an NHS optical voucher and for the purposes of prevention, detection and investigation of crime, I consent to the disclosure of relevant information, including to and by the Prescription Pricing Authority, Department for Works and Pension and Local Authorities. I will pay the cost of the voucher value if I am later found not to be entitled. In addition, a statutory penalty may be payable.

☒ I am the patient ☒ I am the patient's parent, guardian or carer

Signature: ..... Date: ...../...../.....

If the patient is under years 16 or incapable of signing, their parent, carer or other person responsible for them must sign.

Enter Surname, Forename, Address and Postcode in BLOCK LETTERS or attach patient details sticker

Enter only if patient has changed name since previous visit

Enter voucher type in appropriate box(es)

Enter prescription

Enter relevant details

Enter "x" in appropriate box

Enter prescriber's name in BLOCK LETTERS

Prescriber to sign and date

To be completed by patient/parent/ guardian/carer when they order the glasses/ contact lenses

Enter date of birth

Enter "x" in appropriate box

Leave blank

Enter date of sight test to which voucher relates

Enter hospital registration number

Enter "x" in appropriate box(es) to show if supplement(s) prescribed

Add hospital stamp

HES(S)(3) **B**

Part 2 PATIENT'S STATEMENT

To be completed by patient/ parent/guardian/ carer on receipt of glasses/ contact lenses

I confirm that I have received ☐ pairs of glasses ☐ contact lenses on: ...../...../.....
under the NHS optical voucher scheme

☒ I am the patient ☒ I am the patient's parent, guardian or carer +

Signature: ..... Date: ...../...../.....

Name (if not the patient) .....

Address .....
(if different to above)

..... POSTCODE .....

\+ *If the patient is under 16 years or incapable of signing, their parent, carer or other person in charge of them must sign*

Part 3 SUPPLIER'S DECLARATION

In accordance with the prescription overleaf I have supplied:

☒ glasses ☒ contact lenses

To be completed by the supplier who dispenses glasses/contact lenses

I claim under the NHS optical voucher scheme as follows:

Actual cost of glasses/contact lenses if less than or equal to voucher value(s) plus any supplement(s)

		1st pair £	1st pair P		2nd pair £	2nd pair P	
Voucher value(s)				+			(1)
+ Supplement(s)	☒ Complex						(2)
	☒ Prism						(3)
	☒ Tint						(4)
	☒ Small glasses†						(5)
	☒ Special frames						(6)
				+			(7)

Total of voucher(s) and supplement(s) (*sum of* 2,3,4,5+6) +

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) £ ☐☐☐–☐☐

I declare that the information I have given on this form is correct and complete and I understand that if it is not action may be taken against me. I claim payment of fees due to me for the dispensing of this voucher.

Date of first/only pair supplied D D – M M – Y Y Y Y

Date of second pair supplied D D – M M – Y Y Y Y

\+

Supplier's signature:

Date: D D – M M – Y Y Y Y

Ophthalmic list number* ☐☐☐☐☐☐☐☐☐☐☐☐

GOC Number* ☐☐–☐☐☐☐

* *if applicable*

Payment location code ☐☐☐☐☐☐

Supplier's stamp

\+

† *As defined in the NHS (Optical Charges and Payments) (Scotland) Regulations 1998, as amended*

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HES(S)(R) HES optical repair/replacement voucher application form

Fill in your details at Part 1, sign and date Part 2 and give the form to the person who will repair or replace your glasses or contact lenses (more information is in leaflet HC11). After the repair/replacement, you will be asked to sign and date Part 3.

You cannot get help if your glasses/contact lenses are covered by warranty, insurance or after care service. If you are aged 16 or over, you must satisfy the hospital that your glasses or contact lenses were lost or damaged because you were ill.

Enter Surname, Forename, Address and Postcode in BLOCK LETTERS or attach patient details sticker

Enter only if patient has changed name since last visit

Enter date of birth

Enter "x" in appropriate box

Leave blank

Enter date of sight test to which voucher relates

Enter hospital registration number

Part 1 PLEASE USE BLACK INK AND BLOCK CAPITALS PATIENT'S DETAILS

SURNAME .....

FORENAME .....

ADDRESS .....

..... POSTCODE .....

PREVIOUS SURNAME .....

D.O.B. .....

MALE ☐ FEMALE ☐

PATIENT IDENTIFIER (for CSA use) ☐☐☐☐☐☐☐☐☐☐

DATE OF SIGHT TEST ...../...../.....

HOSPITAL REGISTRATION NO .....

Cross the appropriate box to tell us the reason why you are entitled to a voucher.

To be completed by patient/parent/ guardian/carer when ordering replacement/ repair to glasses/contact lenses

☐ The patient is under 16

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

Name of School/College/University .....

Address .....

..... POSTCODE .....

I/my partner receive(s):

☐ Income Support

☐ Income-based Jobseeker's Allowance†

☐ Pension Credit guarantee credit

☐ I am/my partner is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate

Name of person getting the benefit if not the patient:

..... D.O.B. ...../...../.....

☐ I/my partner have an HC2 certificate No .....

☐ I/my partner have an HC3 certificate No .....

- which shows by **box B** of certificate HC3 the value of the voucher will be reduced by £ .....

☐ I have been prescribed complex lenses as defined for the purposes of the NHS voucher scheme

☐ If over 16, explain below how the loss or damage happened:

	Hospital stamp

Part 2 PATIENT'S DECLARATION

I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to an NHS optical repair/replacement voucher and for the purposes of prevention, detection and investigation of crime, I consent to the disclosure of relevant information, including to and by the Prescription Pricing Authority, Department for Works and Pension and Local Authorities. I will pay the cost of the voucher value if I am later found not to be entitled. In addition, a statutory penalty may be payable.

☐ I am the patient ☐ I am the patient's parent, guardian or carer

Signature: ..... Date: ...../...../.....

Name (if not the patient) .....

Address (if different to above) .....

..... POSTCODE .....

If the patient is under 16 years or incapable of signing, their parent, carer or other person in charge of them must sign.

HES(S)(R) **B**

Part 3 PATIENT'S STATEMENT

To be completed by patient/ parent/guardian/ carer on receipt of repaired/ replaced glasses/ contact lenses

I confirm that my glasses/contact lenses have been repaired ☒ replaced ☒

☒ I am the patient ☒ I am the patient's parent, guardian or carer

Signature: ..... Date: ...../...../.....

If the patient is under 16 years or incapable of signing, their parent, carer or other person in charge of them must sign.

Part 4 SUPPLIER'S DECLARATION

In accordance with the prescription and details below I have:

☒ repaired ☒ replaced the glasses/contact lenses for the person named at **Part I** of this form.

Voucher type: D N Supplements: D N *Complex* D N *Prism* D N *Tint*

To be completed by supplier who undertakes repair/ replacement

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

Voucher value appropriate to the above prescription

Parts: Lens ☒ Right ☒ Left ☒ Both

Frame ☒ Front ☒ Side ☒ Whole

Supplements: ☒ Complex ☒ Prism ☒ Tint ☒ Small glasses†/specially made frames supplement

£	P	
		(1)
		(2)
		(3)
		(4)
		(5)
		(6)
		(7)

I claim under the NHS optical voucher scheme:

	£	P	
Voucher value plus any supplement(s) (*sum of* 1+(4+5+6+7))			(8)
or part(s) per current PCA (O) plus any supplement(s) (*sum of* (2+3)+(4+5+6+7))			(9)
or actual retail cost			(10)
Patient's contribution as shown by **box B** of certificate HC3 *(if applicable)*			(11)

Total claim (8 ***or*** 9 ***or*** 10 - *whichever is the lowest*, minus 11) £ □□□ – □□

I declare that the information I have given on this form is correct and complete and I understand that if it is not action may be taken against me. I claim payment of fees due to me for the dispensing of this voucher.

Supplier's signature:

Date: D D – M M – Y Y Y Y

Ophthalmic list number* □□□□□□□□□□□□

GOC Number* □□ – □□□□

* *if applicable*

Payment location code □□□□□□

Supplier's stamp

† As defined in the NHS (Optical Charges and Payments) (Scotland) Regulations 1998, as amended

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