NHS
Portsmouth
Clinical Commissioning Group

GLAUCOMA MONITORING SCHEME CLAIM FORM

Optician's Name	**Month of Claim**
Address	**Quarter claim was submitted** Q1 / Q2 / Q3 / Q4

Date of Examination	**Appointment offered at appropriate interval (YES/NO)**	**Patient ID (NOT NHS No)**	**Post Code**	**GP Surgery Name**	**Claim Amount £**

£50 per full examination, £40 per examination without field test, £30 per repeat examination	**Total £**

I confirm I have carried out the examination on the persons above and I understand that if I give information that is incorrect or incomplete, action may be taken against me.

Optometrist's Signature _____ **Print Name** _____ **Date** _____

Please return at the end of each quarter by 10th of the following month; to Leigh Spurling, St. James' Hospital, Locksway Road, Portsmouth, PO4 8LD