NHS
Portsmouth
Clinical Commissioning Group

LOW VISION SCHEME CLAIM FORM

Optician's Name				**Month of Claim**	
Address				**Quarter claim was submitted** Q1 / Q2 / Q3 / Q4	
Date of Examination	**Patient ID (NOT NHS No)**	**Post Code**	**Appliance Supplied**	**GP Surgery Name**	**Claim Amount £**
£60 per low vision assessment				**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