A close-up of a logo

Description automatically generated with medium confidence

|  |  |
| --- | --- |
| Application for non-tolerance voucher |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | | **Practice Address** | | | | | | | | |
| Initials | | | | | | | | |
| D.O.B | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | Telephone | | | | | | | | |
|  | | | | | | | | | Fax | | | | | | | | |
|  | | | | | | | | | Contact Name | | | | | | | | |
| Date of Application | | | | | | | | | Role / Job Title | | | | | | | | |
| **Reason for Non Tolerance** (Ref: Making Accurate Claims 2024 Section 22 page 36) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Lens Type | | | Initial voucher type | | | | | Date of supply | | | | | Length of wear | | | | |
| **Action Proposed** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Original Prescription** | | | | | HES / GOS? | | Exam Date | | | | | OCs Dist/Near | | | | | BVD |
| RE | Vision | SPH | | CYL | | | AXIS | | | PRISM | | BASE | | | VA | | ADD |
|  |  |  | |  | | |  | | |  | |  | | |  | |  |
| LE | Vision | SPH | | CYL | | | AXIS | | | PRISM | | BASE | | | VA | | ADD |
|  |  |  | |  | | |  | | |  | |  | | |  | |  |
| **New Prescription** | | | | | Retest Date | | | | | | | OCs Dist/Near | | | | BVD | |
| RE | Vision | SPH | | CYL | | | AXIS | | | PRISM | | BASE | | | VA | | ADD |
|  |  |  | |  | | |  | | |  | |  | | |  | |  |
| LE | Vision | SPH | | CYL | | | AXIS | | | PRISM | | BASE | | | VA | | ADD |
|  |  |  | |  | | |  | | |  | |  | | |  | |  |
| **ICB USE ONLY** | | | | | | | | | | | | | | | | | |
| REQUEST AUTHORISED BY  (Ophthalmic Advisor) | | | | | | Name (PRINT) | | | | | Signature | | | Date | | | |
| Request authorised by  (ICB) | | | | | | Name (PRINT) | | | | | Signature | | | Date | | | |

**PLEASE RETURN FORM by secure email** to [**lscicb-bl.optom@nhs.net**](mailto:lscicb-bl.optom@nhs.net)

Providers please note that nhs.net email should be used when emailing.

\*Please do not include patient identifiable information

Please attach this form to the GOS3 if the application has been approved.