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| Application for non-tolerance voucher |  |

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| **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**

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.