

**AUTHORISATION TO CLAIM EXPENSES TOWARDS THE COST OF  
PRESCRIPTION SPECTACLES/CONTACT LENSES THROUGH JPA**

*Protect Medical once completed*

**All Parts of this form MUST be completed**

**HEAD OF HOUSEHOLD DETAILS**

Number		Rank		Surname	
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<b>Full</b> Unit Address (Including BFPO No.)	
E-mail Address	
Tel No.	

**PATIENT DETAILS** (\*Spouse / \*Child)

Surname		Forename		DOB	
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**REASON FOR CLAIM:** \*Prescription Spectacles / \*Prescription Contact Lenses.

I declare that the charges being claimed are as a direct result of visiting the following

Optician Facility: \_\_\_\_\_ on (date): \_\_\_\_\_

**DETAILS OF CLAIM** (Please refer to notes on completion 1 - 4)

Cost claimed relates to **one** prescription charge.

Cost claimed: \_\_\_\_\_ (a copy of the prescription, invoice and receipt **must** be attached)

Signed: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

\* Delete as applicable

**NOTES ON COMPLETION**

1. This form is to be used to claim expenses incurred by eligible dependants based in BFG, SHAPE, Ramstein and Brunssum towards the cost of prescription spectacles or contact lenses up to a maximum value of £70.00 (equivalent Euro rate calculated at the FFR at the time of expenditure). To confirm eligibility please refer to guidance notes located in the HC12 NHS (England) Quick Guide Leaflet (1 Apr 16) available to view online at:

[http://www.nhsbsa.nhs.uk/Documents/HealthCosts/HC12\\_April\\_2016.pdf](http://www.nhsbsa.nhs.uk/Documents/HealthCosts/HC12_April_2016.pdf)

2. All claims for reimbursement are to be submitted within **one month** of the period concerned or the date on which the expenditure was incurred as directed in:

**JSP 752 Pt 2 (V29.0 Jan 17) 10 - 2 - A - 1**

3. This excludes prescription spectacles required for Display Screen Equipment (DSE).

**Failure to provide the relevant documentation may result in your claim being delayed or declined.**

4. When claiming expenses for prescription spectacles/prescription contact lenses the following documentation is mandatory:
- ✓ A copy of the sight test prescription
  - ✓ A copy of the invoice
  - ✓ A copy of the credit card receipt or a stamped and signed receipt from the optician if paid by cash

Once complete all documentation is to be forwarded electronically to:

DII: DPHC(BFG)-HQ-Billing-Clk  
 Civilian: DPHCBFG-HQ-Billing-Clk@mod.uk

Alternatively you can send them by post to the following address:

Billing Administrator HQ BFG Health Service Lake House Catterick Barracks Bielefeld BFPO 39	or	Billing Administrator HQ BFG Health Service Lake House Catterick Kaserne Detmolder Str 440 33605 Bielefeld Germany
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Financial authorisation will be given and a unique reference number and relevant UIN will be emailed to the Service Person to enable them to claim back via JPA.

**You are to ensure you annotate both the unique reference number and UIN on JPA when making your claim.**

If you have any questions regarding the completion of this form please contact the Billing Administrator, HQ BFG Health Service on:

**(Mil)** 94881 2785 or **(Civ)**: 0049 (0)521 9254 2785