FP92A Application for prescription charge exemption (medical)

This form will be processed more quickly if you fill it in using BLACK INK in BLOCK CAPITALS inside the boxes

FP92A0710

Making an Application

The patient should fill in **Part 1** and **Part 2**. A doctor (or a member of the practice) should complete **Part 3**. When completed send the form to: NHS Business Services Authority, Prescription Exemption Applications, Bridge House, 152 Pilgrim Street, Newcastle upon Tyne NE1 6SN, in the envelope provided.

Note: We need your date of birth to ensure you are not already age exempt.

Part 1 ABOUT YOUR MEDICAL CONDITION

I declare that: *(tick the box that applies) (but only one box)*

I have:

- ☐ A permanent fistula (for example caecostomy, colostomy, laryngostomy or ileostomy) requiring continuous surgical dressing or requiring an appliance.
- ☐ Epilepsy for which I need continuous anti-convulsive therapy.
- ☐ Diabetes mellitus and my treatment is not just by diet alone.
- ☐ Myxoedema (that is, Hypothyroidism requiring thyroid hormone replacement).
- ☐ Hypoparathyroidism.
- ☐ Diabetes insipidus or other forms of hypopituitarism.
- ☐ Forms of hypoadrenalism (including Addison's disease) for which specific substitution therapy is essential.
- ☐ Myasthenia gravis.
- ☐ A continuing physical disability which means I cannot go out without the help of another person. Temporary disabilities do not count even if they last for several months, or

I am undergoing treatment for:

- ☐ Cancer:
  - including for the effects of cancer; or
  - the effects of current or previous cancer treatment.

Part 2 ABOUT YOU

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname:

First name:

House No: Street:

Town:

Postcode: Date of Birth (IMPORTANT): D D M M Y Y

Telephone number

NHS no. *(from your medical card):*

PATIENT DECLARATION

This is my application for a prescription charge exemption certificate. I declare that the information I have given in Parts 1 & 2 of this form is true and complete and I understand that if it is not, appropriate action may be taken.

Signature Date D D M M Y Y

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Part 3 DOCTOR'S STATEMENT

This form can be signed by a GP, hospital or service doctor. Also, at the GP's discretion, by a member of the GP practice who can access the patient's medical record to confirm the patient's statement.

Doctor or practice staff declaration: I confirm that the information given by the patient in Part 1 is correct and that the information given in Part 2 is in accordance with the patient's records.

Position if not a doctor

Signature

Date D D M M Y Y

GP's or hospital doctor's stamp; or service doctor's name, rank, and establishment:

Data Protection Act 1998: The NHS Business Services Authority will use the information that you have provided on this application form for the processing of your application. We will not disclose your Personal Data to any third party or transfer it outside of the European Economic Area. We may contact you to discuss your application. Your Personal Data will be deleted from our systems and files no later than 24 months after the date of the expiry of the certificate.