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

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 to 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.

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Part 2 ABOUT YOU

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname:

First name:

House No/Name:

Street:

Town:

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

Telephone number in case we need to contact you:

Email address:

NHS no. (from your medical card):

PATIENT DECLARATION

This is my application for a prescription charge medical exemption certificate. I understand that the information I have provided will be used by the health services to check for fraud and incorrectness and to secure the effective and efficient delivery of prescribing and dispensing services. I understand this means that relevant information from this form will be disclosed to and by the NHS Business Services Authority, Department of Health, NHS England, NHS Protect and the Health and Social Care Information Centre and bodies performing functions on their behalf, and to the extent I need to I consent to this. I understand that the NHS Business Services Authority will use the information to process my application. They will not transfer my personal data outside of the European Economic Area. They may contact me to discuss my application and the quality of the service. My personal data will be deleted no later than 24 months after the certificate expires. Further details at www.nhsbsa.nhs.uk/privacypolicy.aspx. **I declare that the information I have given on this form is correct and complete and I understand that if it is not appropriate action may be taken.** NOTE: If the patient is unable to complete the form themselves the doctor (or a member of the practice) can do so on the patient's behalf and they must print their name in the patient signature box in part 2 and complete Part 3.

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 assess the patient's medical records to confirm the patient's statement.
Doctor or practice staff declaration: I confirm that the information given by the patient in Part1 is correct and that the information given in Part 2 is in accordance with the patient's records.

Position if not a doctor

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

Signature Date D D M M Y Y