**Registration form for practices wishing to provide Services**

You have received this document because your practice has expressed an interest in providing the service listed in Section 2 (“the Services”) as a sub-contractor to the Primary Eyecare Company (“the PEC”) named in Section 1.

|  |
| --- |
| **Section 1** |
| Name of Primary Eyecare Company | **Ocular Outcomes Ltd** |

|  |
| --- |
| **Section 2** |
| Commissioner | Service |
| Bedfordshire and Luton CCG |  **CUES** |

|  |
| --- |
| **Section 3** |
| contact | Lisa Barker lisabarkerocular@gmail.com |

Before your practice can provide the Service a contract must be in place between your practice and the Ocular Outcomes .

The forms which follow collect the information which the Ocular Outcomes requires to: prepare the contractual documentation; set up your practice to provide the Services; and ensure payment is made to your practice for the Services provided.

There are three forms which you must complete and return:

* **Form A**: To confirm accurate practice details and to set up an account on pharmoutcomes which is a web-based platform which will be used to manage the service
* **Form B**: Details for the contract between the Ocular Outcomes and your practice.
* **Form C**: Details of the bank account into which payment is to be made

The information you provide will be used solely for the purposes of administering the Services and the sub-contract.

How to return this form:

Please complete this form and return by email to: lisaocular@gmail.com

**Form A: Practice details**

*These details will be used by the Ocular Outcomes to administer the Service and by Pharmoutcomes to set up your registration on the IT system*

**One form is required for each practice (location) providing the service.**

A.1 Person completing these forms:

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Contact Telephone number** |  |
| **Email address** |  |
|  |  |
|  |  |
|  |  |

A2. Practice details:

|  |  |
| --- | --- |
| **Name of practice****(This is the trading name of the practice)** |  |
| **Address of practice** |  |
| **Postcode of practice** |  |
| **Telephone number of practice****(including STD)** |  |
| **Please Indicate which Service the Practice will sign up to** | Bedford CCG MECS / Spamedica post operative assessment  |

A3. Please provide details of the person who will be taking day to day responsibility for this service at this practice and who can be contacted by the PEC in the event of a service issue:

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address** |  |

**Form B: Contract information**

*For the purposes of this service the practice is a sub-contractor to Ocular Outcomes. A contract must be in place between Ocular Outcomes and the sub-contractor (the practice). This contract must be signed by a person authorised to do so for the sub-contractor (the practice).*

*IMPORTANT: For the purposes of this contract the sub-contractor must be the legal entity which holds a GOS Mandatory Services contract with the NHS.*

*The information provided below will be used to populate the contract prepared for your practice.*

**One form is required for each practice (location) providing the service.**

1. Type of legal entity: Please complete **one** of the following rows for the practice

|  |  |
| --- | --- |
| Individual: |  |
| Write name above |
| Partnership: |  |
| Write name of partnership above |
| Limited Company: |  |
| Write name of Limited Company above |

Limited companies: For limited companies please complete the following information:

|  |  |
| --- | --- |
| **Registered Address****(including postcode)** |  |
| **Company Registration Number** |  |

Authorised signatory: Please provide details of the person who is authorised to sign the contract for the practice?

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Title / Position** |  |
| **Telephone number** |  |
| **Email address** |  |

**Form C: Payments made by Ocular Outcomes to the sub-contractor:**

*Ocular Outcomes will make payment to the sub-contractor for the services provided by the directly into a bank account nominated by you.*

*Note: cheque payment is not possible.*

**One form is required for each practice (location) providing the service.**

C1. Please provide details of the person who will be responsible for receiving payment remittance advice. **Note – an email address is essential.**

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address (essential)** |  |

C2. Bank Details: provide details of the bank account into which payment should be made

**Name(s) of Bank Account Holder(s):**

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Bank/Building society account number:** |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Branch Sort Code:** |  |  | - |  |  | - |  |  |

|  |  |
| --- | --- |
| **Bank Name** |  |
| **Branch Name** |  |