

GP LENS REQUEST FOR MODIFICATION

Please keep this form in your patient's file as it must be filled out completely when returning lenses for modification.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____ Contact Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Original Invoice Number: _____
 Original Invoice Date: _____
 Lenses Returned For: () Clean & Polish Only () Modification
 Modification Instructions:
 O.D. _____
 O.S. _____



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

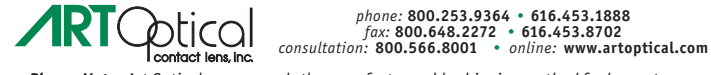
All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848

GP LENS REQUEST FOR CREDIT

Please keep this form in your patient's file as it must be filled out completely when returning lenses for credit.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Returned Invoice Number: _____
 Reorder Invoice No.: _____
 Reason for Return:
 Refit: BC Diameter Power Add Other _____
 Outside Tolerance: BC Diameter Power Add Other _____
 Patient Cancellation Broken Lens Wettability Surface



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848

GP LENS REQUEST FOR MODIFICATION

Please keep this form in your patient's file as it must be filled out completely when returning lenses for modification.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____ Contact Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Original Invoice Number: _____
 Original Invoice Date: _____
 Lenses Returned For: () Clean & Polish Only () Modification
 Modification Instructions:
 O.D. _____
 O.S. _____



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848

GP LENS REQUEST FOR CREDIT

Please keep this form in your patient's file as it must be filled out completely when returning lenses for credit.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Returned Invoice Number: _____
 Reorder Invoice No.: _____
 Reason for Return:
 Refit: BC Diameter Power Add Other _____
 Outside Tolerance: BC Diameter Power Add Other _____
 Patient Cancellation Broken Lens Wettability Surface



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848

GP LENS REQUEST FOR MODIFICATION

Please keep this form in your patient's file as it must be filled out completely when returning lenses for modification.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____ Contact Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Original Invoice Number: _____
 Original Invoice Date: _____
 Lenses Returned For: () Clean & Polish Only () Modification
 Modification Instructions:
 O.D. _____
 O.S. _____



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848

GP LENS REQUEST FOR CREDIT

Please keep this form in your patient's file as it must be filled out completely when returning lenses for credit.

ART OPTICAL USE ONLY
Date Received: _____

Account Name: _____
 Account Number: _____ Ship To Number: _____
 Patient Name: _____
 Returned Invoice Number: _____
 Reorder Invoice No.: _____
 Reason for Return:
 Refit: BC Diameter Power Add Other _____
 Outside Tolerance: BC Diameter Power Add Other _____
 Patient Cancellation Broken Lens Wettability Surface



Please Note: Art Optical recommends the use of a traceable shipping method for lens returns. We are not responsible for lenses that do not arrive at our facility. Lenses ordered non-warranted or that are past the purchased warranty period are non-returnable.

All lenses must be returned **DRY**, send to: 3175 3 Mile Rd. NW, Walker, MI 49534
If using first class mail (not recommended): P.O. Box 1848, Grand Rapids, MI 49501-1848