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. _____

ART Optical contact lens, inc.
phone: **800.253.9364 • 616.453.1888**
fax: **800.648.2272 • 616.453.8702**
consultation: **800.566.8001** • *online:* **www.artoptical.com**

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

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8/11 cs111.1.f

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1/10 ac116.3.f

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