

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

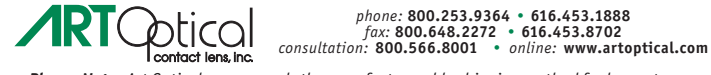
8/11 cs111.1.f

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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