

## GP LENS REQUEST FOR MODIFICATION

Please keep this form in your patient file as it must be included when returning lenses for modification.

Account Name:	_____
Account Number:	_____
Contact Name:	_____
Patient Name:	_____
Original Invoice Number:	_____
Original Invoice Date:	_____
Reason for Return:	<input type="checkbox"/> Neutralize <input type="checkbox"/> Clean/Polish <input type="checkbox"/> Add Power <input type="checkbox"/> Modify
Modification Instructions:	_____
O.D.	_____
O.S.	_____

Lenses with Tangible Hydra-Peg surface treatment may be neutralized only.



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

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## GP LENS REQUEST FOR CREDIT

Please keep this form in your patient file as it must be completed & included when returning lenses for credit.

Account Name:	_____
Account Number:	_____
Patient Name:	_____
Returned Invoice Number:	_____
Reorder Invoice No.:	_____
Reason for Return:	_____
Refit:	<input type="checkbox"/> BC <input type="checkbox"/> Diameter <input type="checkbox"/> Power <input type="checkbox"/> Add <input type="checkbox"/> Other _____
Outside Tolerance:	<input type="checkbox"/> BC <input type="checkbox"/> Diameter <input type="checkbox"/> Power <input type="checkbox"/> Add <input type="checkbox"/> Other _____
	<input type="checkbox"/> Patient Cancellation <input type="checkbox"/> Broken Lens <input type="checkbox"/> Wettability <input type="checkbox"/> Surface



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Original Invoice Date:	_____
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