# ART Optical contact lens, inc. CUSTOM LENS RETURN AUTHORIZATION FORM

DATE OF RETURN:_____ ACCOUNT #: _____

INVOICE #: _____ ❑ RIGHT LENS ❑ LEFT LENS ❑ PAIR

PATIENT NAME: _____

**LENS RETURNS ARE NOT REQUIRED FOR PARAMETER & Rx ADJUSTMENTS UNDER WARRANTY**

*To request credit for warranted lenses exchanged for fit or Rx,* DO NOT USE THIS FORM. *Simply submit your eligible return information @ www.artoptical.com/credit*

**REASON FOR RETURN:**

❑ **PATIENT CANCELLATION** For credit consideration in the case of Patient Cancellation, all lenses ordered for the patient must be returned with this completed form - no RA# required.

❑ **OTHER** For credit consideration in all "OTHER" cases, a **Return Authorization # is required prior to lens return. Contact Art Optical @ 800.253.9364 for RA#**. *NOTE: Lenses received at our facility without an RA# will not be eligible for credit and cannot be returned to sender.*

**RA#:**_____

**LENS RETURN REQUIREMENTS:**

Custom soft lenses must be returned in original glass vials with labeling intact. Custom GP lenses must be returned DRY in original packaging. All physical lens returns must be accompanied by this completed form. Return shipping costs and proof of delivery on returned product is the responsibility of the sender. Returned lenses are inspected upon receipt to determine credit eligibility and per FDA regulation, cannot be returned to sender.

**Return lenses via a traceable shipping method to:**
**ART OPTICAL CREDIT DEPT.**
**3175 3 Mile Road NW, Walker, MI 49534**