Always Ahead of the Curve

METRO OPTICS

800-223-1858

www.metro-optics.com

Warranty Return Form

Rx Cancellation Limited to 90 Days

Aprvd: SJW
Ver: 000
Rev. Date: 12/04/13

Name of person making return:_____

Name of practice:_____

Account #:_____

Date of order:_____

Original Invoice#_____

Patient Name:_____

Reason for Return:(Circle)

Rx Change

Broken/Torn

Defective
Describe Defect:_____
_____

Other:_____

Return Qualification Checklist: (**Must be complete to receive credit**)

- ☐ All fields on form filled out
- ☐ Original invoice copy attached
- ☐ If Soft lenses; in their original packaging

Return addresses:

By: U.S. Mail - P.O. Box 81189, Austin, TX 78708

By: FedEx/UPS/Etc. - 15802 Vision Drive, Pflugerville, TX 78660