REFUND/ MONEY TRANSFER FORM

PRODUCT MUST BE SENT WITH THIS FORM

OFFICE: _____ ACCT. #:_____ TODAY'S DATE: _____

PT. NAME: _____ DATE OF ORIGINAL ORDER: _____

LAB: LOCAL _____WALMAN_____DUFFENS_____

HOW MANY PAIRS OF ACTIVE GLASSES DOES PATIENT HAVE?_____

WAS INSURANCE BILLED OUT ON ORIGINAL ORDER: YES_____ NO_____

ORDERING OPTICIAN: _____ ORDERING DR:_____

REFUND TO PATIENT: YES _____ AMOUNT_____ NO_____

ADDITIONAL DUE YES____ AMOUNT_____ NO____

NEVER REFUND AN EXAM OR FITTING FEE

CHOOSE REASON FOR REMAKE/ REFUND:

NON ADAPT ____LAB ERROR ____SCRATCH COAT ____DR. RX. CHANGE_____

WARRANTY ____PT. UPGRADE ____PT. DOWNGRADE ____FRAME_____

PT. NEVER PICKED UP ____OPTICIAN ERROR EXPLAIN_____

PT. SATISFACTION EXPLAIN_____

OTHER EXPLAIN_____

OPTICIAN FILLING OUT FORM:_____ DATE:_____

SUPERVISOR SIGNATURE:_____ DATE:_____

DR. SIGNATURE:_____ DATE:_____

PLEASE LET PATIENT KNOW 4-6 WEEKS PROCESSING TIME.

SCAN REFUND FORM INTO COMPULINK

SEND FORM AND THE PRODUCT IMMEDIATELY TO CENTRAL SUPPLY ATT: JAMI

VOID ORIGINAL JOB AND FILL OUT THIS FORM ENTIRELY

FINAL APPROVAL REFUND PROCESSOR:_____ DATE:_____