



smartmedcare.com

REASON FOR EXCHANGE: _____

Payment Information: If the total of your exchange or new order exceeds the value of your return, please provide method of payment.

CARDHOLDERS NAME: _____

TYPE OF CREDIT CARD: _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: __/__/__ SIGNATURE: _____

Thank You. You will be notified by email as soon as we receive and process your completed Contact Lens Product Return and Exchange form.