1800 contacts

Dear Eye Care Provider,

We are requesting the contact lens prescription for the following customer pursuant to the Fairness to Contact Lens Consumers Act (Public Law 108-164), which requires the prescriber to provide a copy of the contact lens prescription to any person designated to act on behalf of the patient. This customer has authorized 1-800 CONTACTS to request this information on his/her behalf. This is not a contact lens order verification request.

Please either (A) send us a copy of the customer's actual prescription, or alternatively, (B) complete and send back to us the Prescription Form below, including all parameters, applicable dates, and signature.

The actual prescription or Prescription Form should be sent to our toll-free fax number 1-888-407-2020 **by 09/15/2015**. Please return this form even if the parameters below are correct.

Patient Name: [redacted]

Address: [redacted]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Advance for Astig. 6pk	-2.75	8.60	14.5	-1.25	170
OS	Acuvue Advance for Astig. 6pk	-1.75	8.60	14.5	-1.75	170

Exam Date: M M D D Y Y Y Y

Rx Issue Date*: M M D D Y Y Y Y

Rx Expiration Date: M M D D Y Y Y Y

octor's Signature: _____

he term "Rx Issue Date" is the date on which the patient receives a copy of the prescription at the completion of their contact lens fitting

Absent a valid medical reason, the prescription cannot expire less than one year after the issue date in any state (or, in states that permit ger prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reas deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgmen umented and attached. Note that this information may be provided to the patient.