

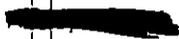
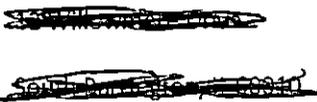
1800 contacts™

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 04/01/2015. Please return this form even if the parameters below are correct.

Patient Name:  Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	1-Day Acuvue Moist (90pk)	-3.75	8.50	14.2	0.00	0
OS	1-Day Acuvue Moist (90pk)	-3.75	8.50	14.2	0.00	0

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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1 800 contacts™

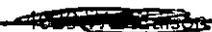
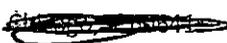
Dear Eye Care Provider,

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 04/02/2015. Please return this form even if the parameters below are correct.

Patient Name: 

Address: 


	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biofinity 6pk	-3.25	8.60	14.0	0.00	0
OS	Biofinity 6pk	-3.00	8.60	14.0	0.00	0

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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1 800 contacts

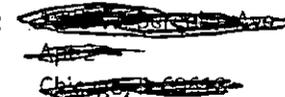
Dear Eye Care Provider,

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 04/02/2015. Please return this form even if the parameters below are correct.

Patient Name: 

Address: 
Chicago, IL

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biofinity Gpk	-3.25	8.60	14.0	0.00	0

OS						
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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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1144062

1800 contacts®

Dear Eye Care Provider,

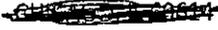
We are requesting the contact lens prescription for the following customer pursuant to the Fairness to Contact Lens Consumers Act (Public Law 108-164), which requires the prescriber to provide a copy of the contact lens prescription to any person designated to act on behalf of the patient. This customer 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 06/02/2015. Please return this form even if the parameters below are correct.

Patient Name: 

Address: 



	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Advance for Astig. 6pk	-6.00	8.60	14.5	-1.75	30
OS	Acuvue Advance for Astig. 6pk	-5.50	8.60	14.5	-1.75	140

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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1469168

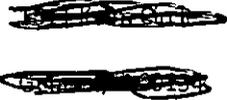
1800 contacts*

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 04/29/2015. Please return this form even if the parameters below are correct.

Patient Name:  Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Dailies Total 190pk	-3.50	8.50	14.1	0.00	0
OS	Dailies Total 190pk	-2.75	8.50	14.1	0.00	0

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

Doctor's Signature: _____

*The 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.

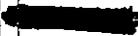
**Absent a valid medical reason, the prescription cannot expire less than one year after the issue date in any state (or, in states that permit longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating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

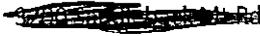
1235718

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
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OD	ClearSight 1 Day 90 pk	-3.25	8.70	14.2	0.00	0
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OS	ClearSight 1 Day 90 pk	-3.25	8.70	14.2	0.00	0
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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

Doctor's Signature

ECP Information: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name:	Pearle Vision	Office Address:	1730 West Fullerton Avenue Suite 1
Doctor:	Johnson Grote OD, Andrea	State:	IL
Phone:	7733273000	City:	Chicago
Fax:	7733273015	Zip:	60614
Email:		Saturday Hours:	

* The 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.

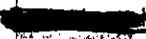
** Absent a valid medical reason, the prescription cannot expire less than one year after the issue date in any state (or, in states that permit longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating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

1018121

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Advance (6pk)	-2.25	8.30	14.0	0.00	0
OS	Acuvue Advance (6pk)	-2.75	8.30	14.0	0.00	0

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

Doctor's Signature

ECP Information: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name: Pearle Vision Office Address: 1730 West Fullerton Avenue
 Suite 1
 Doctor: Johnson Grote OD, Andrea State: IL
 Phone: 7733273000 City: Chicago
 Fax: 7733273015 Zip: 60614
 Email: Saturday Hours:

* The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

990352

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Air Optix for Astigmatism 6pk	-7.00	8.70	14.5	-1.25	180

OS	Air Optix for Astigmatism 6pk	-7.00	8.70	14.5	-0.75	180
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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

Doctor's Signature

ECP Information: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name: Pearle Vision Express Office Address: 1730 West Fullerton Avenue

Doctor: Clinic See State: IL

Phone: 7733273000 City: Chicago

Fax: 7733273015 Zip: 60614

Email: Saturday Hours:

Not a pt. in our office.

* The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1020792

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: [REDACTED] Address: [REDACTED]
[REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Frequency 55 6pk	-5.75	8.70	14.2	0.00	0
OS	Frequency 55 6pk	-5.75	8.70	14.2	0.00	0

Expiration Date:

M	M	D	D	Y	Y	Y	Y

Prescription Date:

M	M	D	D	Y	Y	Y	Y

Issue Date:

M	M	D	D	Y	Y	Y	Y

Signature

Location: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Company Name: Pearle Vision Office Address: 1730 West Fullerton Avenue
Suite 1
 Doctor: Johnson Grote OD, Andrea State: IL
 Phone: 7733273000 City: Chicago
 Fax: 7733273015 Zip: 60614
 Saturday Hours: _____

Issue Date is the date on which the patient receives a copy of the prescription at the completion of their contact lens fitting.

As a medical reason, the prescription cannot expire less than one year after the issue date in any state (or, in states that permit shorter periods, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for issuing the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be provided attached. Note that this information may be provided to the patient.

1075024

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue 2 (6pk)	-7.00	8.70	14.0	0.00	0

OS	Acuvue 2 (6pk)	-6.00	8.70	14.0	0.00	0
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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

Doctor's Signature

ECF information: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name: Pearle Vision Office Address: 1730 West Fullerton Avenue
 Suite 1
 Doctor: Johnson Grote OD, Andrea State: IL
 Phone: 7733273000 City: Chicago
 Fax: 7733273015 Zip: 60614
 Email: Saturday Hours:

* The date of 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 shorter prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1081982

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: [REDACTED]

Address: [REDACTED]
[REDACTED]
[REDACTED]

Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
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OD	1-Day Acuvue Moist (90pk)	-2.50	8.50	14.2	0.00	0
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OS	1-Day Acuvue Moist (90pk)	-2.50	8.50	14.2	0.00	0
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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

Doctor's Signature

If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name: Pearle Vision Office Address: 1730 West Fullerton Avenue
Suite 1

Doctor: Johnson Grote OD, Andrea State: IL

Address: 7733273000 City: Chicago

City: 7733273015 Zip: 60614

Phone: Saturday Hours:

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

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

1085341

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 07/08/2015. 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	Biofinity Toric 6pk	-7.50	8.70	14.5	-0.75	170
OS	Biofinity Toric 6pk	-8.00	8.70	14.5	-0.75	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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1800 contacts®

Prescription Request: Fax the completed form to (888) 407-2020

Prescription Form

Patient Name: XXXXXXXXXX

Address: 709 W Armitage

CHICAGO, IL 60614

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	1-Day Acuvue Moist (90pk)	-7.50	8.50	14.2	0.00	0
OS						

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

Doctor's Signature

ECP Information: If your office information below is incorrect or missing please correct it or fill in the blanks here or on an accompanying fax.

Business Name: Pearle Vision Office Address: 1730 West Fullerton Avenue
 Suite 1
 Doctor: Johnson Grote OD, Andrea State: IL
 Phone: 7733273000 City: Chicago
 Fax: 7733273015 Zip: 60614
 Email: Saturday Hours:

* The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1107710

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 05/11/2015. 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	Biofinity 6pk	-6.50	8.60	14.0	-0.00	0
OS	Biofinity 6pk	-7.00	8.60	14.0	-0.00	0

Exam Date:

0	4	0	4	2	0	1	5
M	M	D	D	Y	Y	Y	Y

Rx Issue Date:

M	M	D	D	Y	Y	Y	Y

Rx Expiration Date:

0	4	0	4	2	0	1	6
M	M	D	D	Y	Y	Y	Y

Doctor's Signature:

Paaris Vision
 1739 W. Fullerton
 Chicago, IL 60614
 773-327-2000

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1325931

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 05/11/2015. 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	Biofinity G&K	-6.50	8.60	14.0	0.00	0
OS	Biofinity G&K	-7.00	8.60	14.0	-0.00	0

Exam Date: 04/04/2015
M M D D Y Y Y Y

Rx Issue Date: [REDACTED]
M M D D Y Y Y Y

Rx Expiration Date: 04/04/2016
M M D D Y Y Y Y

Doctor's Signature: Pearl Vision
1739 W. Fullerton
Chicago, IL 60614
773-327-3000

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

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 08/13/2015. 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 Oasys 12pk	-2.50	8.40	14.0	0.00	0
OS	Acuvue Oasys 12pk	-2.25	8.40	14.0	0.00	0

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

Doctor's Signature: _____

*The 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 longer prescription lengths, the prescription cannot expire before the date specified by the state). If the prescriber has a valid medical reason for deviating from the default prescription length under state law at the time the prescription was issued, we ask that the medical judgment be documented and attached. Note that this information may be provided to the patient.

1 800 contacts*

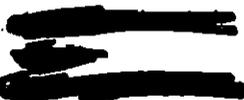
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Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Focus Dailies 90pk	-1.00	8.60	13.8	0.00	0
OS	Focus Dailies 90pk	-1.00	8.60	13.8	0.00	0

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

Doctor's Signature _____

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1800 contacts®

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Patient Name: [REDACTED] Address: [REDACTED]
[REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	1-Day Acuvue Moist (30pk)	-4.00	8.50	14.2	0.00	0
OS	1-Day Acuvue Moist (30pk)	-4.00	8.50	14.2	0.00	0

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

Doctor's Signature: _____

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1794510

1 800 contacts®

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Oasys 24pk	-3.50	8.80	14.0	0.00	0
OS	Acuvue Oasys 24pk	-3.50	8.80	14.0	0.00	0

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

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1336769

1800 contacts*

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD						
OS	Air Optix Aqua 6pk	-2.25	8.60	14.2	0.00	0

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

Doctor's Signature: _____

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1371957

PT NOT FROM THIS OFFICE.

1 800 contacts*

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD						
OS	Air Optix Aqua 6pk	-2.25	8.60	14.2	0.00	0

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

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1371957

PH NOT FROM THIS OFFICE

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Patient Name: _____

Address: _____

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD						
OS	Acuvue 2 (6pk)	-5.25	8.30	14.0	0.00	0

Exam Date: _____

M M D D Y Y Y

Rx Issue Date*: _____

M M D D Y Y Y

Rx Expiration Date: _____

M M D D Y Y Y

Doctor's Signature: _____

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1361139

1800contacts®

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Patient Name: [Redacted]

Address: [Redacted]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Oasys 24pk	-3.75	8.40	14.0	0.00	0
OS	Acuvue Oasys 24pk	-3.75	8.40	14.0	0.00	0

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

Doctor's Signature: _____

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1359904

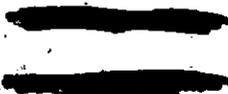
1 800 contacts®

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Patient Name:  Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biomedics XC 6pk	-2.75	8.50	14.2	0.00	0
OS	Biomedics XC 6pk	-1.75	8.50	14.2	0.00	0

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

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD						
OS	Acuvue Oasys for Astig. 6pk	-3.75	8.60	14.5	-1.25	180

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

Doctor's Signature: _____

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1359465

1800 contacts

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Oasys 6pk	-8.00	8.40	14.0	0.00	0
OS						

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

Doctor's Signature: _____

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1359028

1800.contacts

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biomedics 55 6pk	-6.50	8.60	14.2	0.00	0
OS	Biomedics 55 6pk	-7.50	8.60	14.2	0.00	0

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

Doctor's Signature: _____

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1358565

1 800 contacts

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Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue 2 (6pk)	-4.75	8.30	14.0	.00	0
OS	Acuvue 2 (6pk)	-4.75	8.30	14.0	0.00	0

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

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1800 contacts

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Patient Name: [REDACTED] Address: [REDACTED]
[REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Advance (6pk)	-5.25	8.30	14.0	0.00	0
OS	Acuvue Advance (6pk)	-4.75	8.30	14.0	0.00	0

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	Y	Y	Y	Y	Y

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1358338

1800 contacts

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biofinity 6pk	-3.75	8.60	14.0	0.00	0
OS	Biofinity 6pk	-1.25	8.60	14.0	0.00	0

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

Doctor's Signature: _____

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1357887

1 800 contacts

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Soflens 38 6pk	-7.00	8.70	14.0	0.00	0
OS	Soflens 38 6pk	-4.25	8.70	14.0	0.00	0

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

Doctor's Signature: _____

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1246328

1 800 contacts®

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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 05/21/2015. Please return this form even if the parameters below are correct.

Patient Name: [REDACTED] Address: [REDACTED]
[REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue (6pk)	-4.25	8.40	14.0	0.00	0

OS	Acuvue (6pk)	-4.25	8.40	14.0	0.00	0
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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

Doctor's Signature: _____

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1418462

1 800 contacts

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Purevision 6pk	-2.25	8.60	14.0	0.00	0
OS	Purevision 6pk	-2.50	8.60	14.0	0.00	0

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

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on-Sat

1800 contacts

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Patient Name: [REDACTED] Address: [REDACTED]
[REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD:	Biofinity Toric 6pk	4.50	8.70	14.5	-0.75	150
OS:	Biofinity Toric 6pk	4.50	8.70	14.5	-0.75	20

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

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Advance (6pk)	-3.25	8.70	14.0	0.00	0
OS	Acuvue Advance (6pk)	-3.25	8.70	14.0	0.00	0

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

Doctor's Signature: _____

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1364183

1800 contacts®

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Proclear 1 Day Multifocal 30pk	-4.25	8.70	14.2	0.00	0
OS	Proclear 1 Day Multifocal 30pk	-4.25	8.70	14.2	0.00	0

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

Doctor's Signature: _____

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1800 contacts®

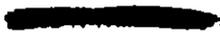
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Patient Name: 

Address: 


	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biomedics XC 6pk	-5.00	8.50	14.2	0.00	0
OS	Biomedics XC 6pk	-5.50	8.50	14.2	0.00	0

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

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1800 contacts

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Oasys 12pk	-4.25	8.40	14.0	0.00	0
OS	Acuvue Oasys 12pk	-4.25	8.40	14.0	0.00	0

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

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1423598

PH NOT FROM THIS OFFICE

1800 contacts

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Patient Name: [REDACTED] Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Acuvue Oasys 12pk	-4.25	8.40	14.0	0.00	0
OS	Acuvue Oasys 12pk	-4.25	8.40	14.0	0.00	0

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

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1800contacts

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Patient Name: [REDACTED]

Address: [REDACTED]

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Soflens 66 Toric 6pk	0.75	8.50	14.5	-1.75	120
OS	Soflens 66 Toric 6pk	1.00	8.50	14.5	-2.25	60

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

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1800 contacts

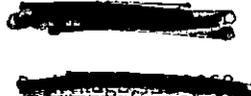
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Patient Name: 

Address: 

	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	1-Day Acuvue Moist (30pk)	-4.00	8.50	14.2	0.00	0
OS	1-Day Acuvue Moist (30pk)	-4.00	8.50	14.2	0.00	0

Exam Date:

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M M D D Y Y Y Y

Rx Issue Date*:

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M M D D Y Y Y Y

Rx Expiration Date:

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M M D D Y Y Y Y

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1418374

1800 contacts®

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Patient Name: 

Address: 


	Brand/Manufacturer	Power	Base Curve	Diameter	Cyl/Add	Axis
OD	Biofinity Toric 6pk	-2.75	8.70	14.5	-0.75	180
OS	Biofinity Toric 6pk	-2.00	8.70	14.5	-1.75	180

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

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1418695