DME/NUTRITIONAL
RETURN AUTHORIZATION FORM

(No merchandise of this type will be accepted without prior authorization)

WAREHOUSE USE ONLY

MFR: _____

CONTACT: _____

PHONE: _____

Pharmacy Name: _____ **Date:** _____

Contact: _____ **Acc. #:** _____

Address: _____

_____

INSTRUCTIONS: Please complete this form and return to Vaue Drug Company Return Goods Dept. via fax: 814-283-2202.

INVOICE #	MANUFACTURER	QUANTITY	DOE #	ITEM DESCRIPTION	SERIAL/LOT #	DEFECTIVE/ DAMAGED	SPECIFY TYPE OF DAMAGE
						☐	
						☐	
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						☐	
						☐	
						☐	
						☐	

Submit by Email

Print Form