



30 Day Money Back Guarantee – Claim Form

For a full refund to be authorised, please complete this form and email it to the Arrotex Pharmaceuticals office at otc.orders@arrotex.com.au
Claim Form must be submitted within 1 week of the consumer's claim being received.

Date: _____

PRODUCT DETAILS

Product: _____

Batch No: _____ Quantity: _____ Date of Purchase: _____

Proof of purchase: _____

Reason for return: _____

PHARMACY DETAILS

Pharmacy Name: _____ State: _____

Pharmacy Account No: _____

Pharmacy Contact Name: _____

Pharmacy Phone Number: _____

CUSTOMER DETAILS

Customer Name: _____

Customer Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone number: _____ Email: _____

I acknowledge I have received a full refund or replacement product: _____
(Customer to sign here)