ReShape Rebate Form

Rewards Program

Date:

Physician Name:

Practice Name:

Patient Date of Insertion:

Patient Information

All fields marked with an asterisk (*) are required in order to process and approve your rebate.

Patient Name*		
Address*		
City*	State*	Zip*
Email*		
Phone*	Mobile	
W-9 Included*	To apply for your rebate please complete this form and send with ***required*** w-9	

Eligible Rebates

Please check the applicable box and enter Patient weight

Initial Weight ☐ $300	3 Months ☐ $300	6 Months ☐ $300	9 Months ☐ $300	12 Months ☐ $300
Weight: Date:	Weight: Date:	Weight: Date:	Weight: Date:	Weight: Date:
Practice Signature:	Practice Signature:	Practice Signature:	Practice Signature:	Practice Signature:

Fax Completed Form to: 949-276-6910

Or Mail Completed Form to:
ReShape Rewards Program
1001 Calle Amanecer
San Clemente, CA 92673

**Do not Email Rebate Form