



Date:

Physician Name:

Practice Name:

Patient Date of Insertion:

Rewards Program

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	
To apply for your rebate, please complete this form and fax to: 949-276-6910		

Eligible Rebates

Please check the applicable box and enter patient weight				
Patient registered on Portal <input type="checkbox"/>	3 Months <input type="checkbox"/> \$300	6 Months <input type="checkbox"/> \$300	9 Months <input type="checkbox"/> \$300	12 Months <input type="checkbox"/> \$300
Initial Weight:	Weight:	Weight:	Weight:	Weight:
Date:	Date:	Date:	Date:	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