

Your Information	Step 1: Account Information										Step 2: Patient Information									
	Ship to Account:										First Name:									
	Account Name:										Last Name:									
	Address:										Age:									
	City: State: Zip:										Last 4 digits of Social Security #:									
	Phone #:										Audiometric Information (required)									
	Contact Name:										Hz: 250 500 1k 2k 3k 4k 6k 8k									
	Email (required):										Right:									
	Bill to Account:										Left:									
	Date: Fitting Date:										Step 3: Fitter's Information									
Purchase Order #:										Fitter's Name:										
										Fitter's Email:										

Lost Product Information	Step 4: Instrument Information										Step 5: RITE and BTE Model Options													
	Model:										If options are not chosen below, they will not be sent with the replacement instrument.													
	Serial Number:																							
	Serial Number:										Speaker													
	Color:										miniFit <input type="checkbox"/> 60 <input type="checkbox"/> 85 <input type="checkbox"/> 100													
	Earmolds										Speaker Units:													
	MicroShells and Power Molds will be covered under the hearing aid L&D warranty.										R		L		Open		OpenBass		Bass Double		Bass Single		Power	
	<input type="checkbox"/> MicroShell		<input type="checkbox"/> Power Mold								<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 5mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm	<input type="checkbox"/> 6mm				
	Custom Product Modifications										<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 6mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm	<input type="checkbox"/> 8mm				
	<input type="checkbox"/> Canal lock		<input type="checkbox"/> Tamper Resistant Battery Door								<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 8mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm	<input type="checkbox"/> 10mm				
<input type="checkbox"/> Clothing loop		<input type="checkbox"/> Removal String								<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 10mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm	<input type="checkbox"/> 12mm					
<input type="checkbox"/> Other:										<input type="checkbox"/> 4	<input type="checkbox"/> 4	Corda miniFit Tube Size:												
										<input type="checkbox"/> 5	<input type="checkbox"/> 5	Corda miniFit Adapter: <input type="checkbox"/> Yes												
Assistive Listening Device																								
<input type="checkbox"/> Transmitter - Serial #																								

How to File a Claim Requirements: Complete form above with the model, color, serial number, patient name, speaker/dome size, if applicable. Custom instruments require a new impression.

Guidelines:

1. There is a one time replacement offered for products within the original warranty that are lost, stolen or damaged beyond repair.
2. No exchanges or upgrades
3. Lost instrument is "Property of Oticon"; if found, return to Oticon, Inc.
4. Replacement unit carries the remainder of the service warranty.
5. Replacement coverage is non renewable for replacement unit.
6. Replacement coverage applies to the product and embedded earmolds only. Replacement does not apply to any accessory items, chargers, demo instruments or custom ear molds.

Audiologist/Consumer signatures authorize Oticon to proceed with this claim based on the guidelines listed above.									
Please briefly describe the reason for instrument replacement:									
Date of Claim: _____ Patient's Signature: _____ Audiologist's Signature: _____									

Please note that as a covered entity, you are required under HIPAA to safeguard protected health information.

Submit to: Oticon, Inc. 580 Howard Ave. Somerset, NJ 08873
 Attn: Government Services Customer Service Email to: vaorders@oticonusa.com
 Fax Number: 763.764.9133 Phone: 877.310.9681