Augmentative and Alternative Communication
Request for Repair Form

Date ____
User's Name _______________________ Phone Number _________________
Mailing Address (Location device should be mailed to) ______________________________
____
Medicaid Number
____
Original Purchase Date _______________ Original Pay Source ____________
Contact Person (Person acting on behalf of user)
____
Phone Number __________________ Email Address ____________________
Device Manufacturer _____________________ Model ____________________
Serial Number____
Manufacturer ____
Address
____
Return Authorization Number ______________________________________
Reason for Returning Device ____
Is device being returned to replace batteries? ____ Yes ____ No _____ Not sure
Other ____
Person completing this form ____
Phone Number _________________ Email Address _____________________

Please send a copy of this form, along with the device, to the manufacturer. Retain one for your records.

Follow Up Notes
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01/15/02