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
_____
_____
_____
01/15/02