Loss & Damage Claim Form

CUSTOMER INFORMATION

SHIP TO

Customer No.:

(Please complete all information including name and phone number)

Phone # ( ) _____ Fax # ( ) _____

Clinic Name _____

Address _____

City _____ State _____ Zip _____

PO# _____

BILL TO

Customer No.:

(Please complete all information including name and phone number)

Phone # ( ) _____ Fax # ( ) _____

Company Name _____

Address _____

City _____ State _____ Zip _____

PATIENT INFORMATION

Name _____

Child: Yes ☐ No ☐ Age _____

Medicaid Patient: Yes ☐ Medicaid # _____

(Required if applicable)

No ☐

PRODUCT INFORMATION

Model _____

Serial # _____

Dispensing Date _____

HOW TO FILE A CLAIM

Requirements

Complete the form above with the model, color, serial number & patient name.

Guidelines

1. There is a one time replacement offered under loss, theft, an damage.
2. No exchanges or upgrades.
3. Replacement unit carries the remainder of the service warranty. Loss and damage coverage is non renewable for replacement unit. Rush service is not available, our standard turn around time is an average of 5 business days.

Clinician/Patient signatures authorizes Oticon Medical to proceed with this claim based on the guidelines listed here.

LOSS/DAMAGE INFORMATION DESCRIPTION

_____

_____

_____

Date of Claim:_____Patient's Signature:_____Clinician's Signature:_____

Submit to: Oticon Medical, LLC
Attn: Customer Service
580 Howard Avenue
Somerset, NJ 08873

Fax Number: 1-732-868-6949

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