Advanced Bionics®

REPLACEMENT PRODUCT REGISTRATION FORM

Thank you for choosing Advanced Bionics. To ensure coverage under your Advanced Bionics limited warranty, please follow these simple steps.

RMA # RMA_NO

1. Please Fill In (*Required Information)

*Date of Replacement			*Signature (who is completing form?)
MONTH	DAY	YEAR	

*Serial Number for New Replacement		
* WRITE S/N FOR NEW ITEM HERE	OR	Place included barcode sticker here:
ITEM TO RETURN RETURNED_ITEM		

2. Verify Patient Information -- Is this information correct? (Please write in any necessary corrections)

Last Name	First Name	M. Initial	Date of Birth		
USER_LAST_NAME	USER_FIRST_NAME	M_I	Month USER_MO	Day USER_DAY	Year USER_YEAR

Street Address	Street Address 2
USER_ADDR1	USER_ADDR2

City	State	Country	Zip/Postal Code
USER_CITY	USER_STATE	USER_COUNTRY	USER_PCC

Telephone: Home (Voice)	Home (TDD)	Work (Voice)	Work (TDD)
USER_PHONE			

Fax	E-mail Address(es)	Patient ID Number
USER_FAX	USER_MAIL	PAT_ID

Current Clinic Name (City, State)	Clinic Telephone No	Clinic Fax
CLINIC_NAME	CLINIC_PHONE	CLINIC_FAX

Medical Professional / Audiologist on Record

Warranty Start Date: **WAR_ST** Warranty End Date: **WAR_EN**

3. Return form (mail in with product being returned or Fax to the number below)

Mail: Advanced Bionics
28515 Westinghouse Place
Valencia, CA 91355
Attn: Customer Service
Tel: 877-829-0026

or

Fax: (661) 362-7795

Information on this card will be collected and used in accordance with legal requirements concerning data protection and confidentiality.

9196300-001 Rev E

COPY_NAME