

SERVICE FORM

1.800.392.9932 FAX 888-768-1867

BILL TO	Acc't #: <input type="text"/>	<input type="text"/>
• Office: _____		
Address: _____		
Address: _____		
City/State: _____		
Zip: _____ P.O. _____		
SHIP TO		
Acc't #: <input type="text"/>		
Date: _____ Phone: _____		
Contact name: _____		
Email: _____		
• Facility: _____		
Address: _____		
Address: _____		
City/State: _____		
Zip: _____		
		RACHAP <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> INDIAN HEALTH <input type="checkbox"/> COMMUNITY CARE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/>

1 PATIENT DATA:

Patient's name: _____	SSN: <input type="text"/>
LAST: <input type="text"/>	
FIRST: <input type="text"/>	
Instrument serial numbers:	
LEFT: <input type="text"/>	<input type="text"/>
RIGHT: <input type="text"/>	<input type="text"/>

2 SERVICE REQUESTED:

L R	
<input type="checkbox"/>	In-warranty repair or remake
<input type="checkbox"/>	Out-of-warranty repair or remake (<i>chargeable</i>)
<input type="checkbox"/>	Loss & Damage claim
<input type="checkbox"/>	Return for Credit

3 SERVICE INFORMATION:

REPAIR			
L R		L R	
<input type="checkbox"/>	Dead 3061	<input type="checkbox"/>	Option/Control missing 3056
<input type="checkbox"/>	Intermittent 3062	<input type="checkbox"/>	Feedback 3068
<input type="checkbox"/>	Weak 3063	<input type="checkbox"/>	Clean and check 3046
<input type="checkbox"/>	Distortion 3064	<input type="checkbox"/>	Poor VC taper 4899
<input type="checkbox"/>	Noisy/Static 3065	<input type="checkbox"/>	Add option 3033
<input type="checkbox"/>	High drain/ Short battery life 3060	<input type="checkbox"/>	Battery door problem 3024
<input type="checkbox"/>	Battery 3059	<input type="checkbox"/>	Program switch bad 3057
<input type="checkbox"/>	Programming problems 3075	<input type="checkbox"/>	Ear-to-ear not working 3076
<input type="checkbox"/>	Fades 3071	<input type="checkbox"/>	Wireless connectivity 3073
<input type="checkbox"/>	Option/Control not functioning 3057	<input type="checkbox"/>	Damaged/ Defective accessory 3028
		<input type="checkbox"/>	Other (<i>specify in comments below</i>)

REMAKE			
L R		L R	
<input type="checkbox"/>	Feedback 3068	<input type="checkbox"/>	Damaged 3027
<input type="checkbox"/>	Loose fit 3011	<input type="checkbox"/>	Wrong/Change color 3002
<input type="checkbox"/>	Tight fit 3012	<input type="checkbox"/>	Lengthen canal 3016
<input type="checkbox"/>	Occlusion 3072	<input type="checkbox"/>	Shorten canal 3015
<input type="checkbox"/>	Protrudes 3014	<input type="checkbox"/>	Change vent size 11104
<input type="checkbox"/>	Hurts/Sore (<i>mark location</i>) 3013	<input type="checkbox"/>	Model change or circuit change 3035
<input type="checkbox"/>	Works out of ear 3011	<input type="checkbox"/>	Other (<i>specify in comments below</i>)

RETURN FOR CREDIT			
L R		L R	
<input type="checkbox"/>	Did not benefit 2015	<input type="checkbox"/>	Too many repairs/remakes 3029
<input type="checkbox"/>	Preferred old device 2016	<input type="checkbox"/>	Duplicate order 2010
<input type="checkbox"/>	Preferred competitor's model 2012	<input type="checkbox"/>	Dissatisfied 2016
<input type="checkbox"/>	Could not adjust/manage device 2016	<input type="checkbox"/>	Discomfort 3029
<input type="checkbox"/>	Damaged 3027	<input type="checkbox"/>	Too many problems 3029
<input type="checkbox"/>	Illness/Death 2017	<input type="checkbox"/>	Changed model/color 3002
<input type="checkbox"/>	Feedback 3068	<input type="checkbox"/>	Ordered in error 2010
		<input type="checkbox"/>	Other (<i>specify in comments below</i>)

4 COMMENTS:

(Please print clearly)

5 MATERIALS:

PLEASE SEND:	<input type="checkbox"/> Impression boxes	<input type="checkbox"/> Shipping labels
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