Rhode Island FVV Device
Replacement/Return Form

Please provide the below information when replacing or returning an FVV device.

- Fill out and email to Steven.Corvese@ohhs.ri.gov.
- A pre-addressed and stamped envelope will be mailed out to your agency.
- Your agency will place the device(s) (up to 6 per envelope) and a copy of the associated replacement/return form(s) in the envelope and mail it.
- Once received, replacement device(s) will be sent and returned devices will be deregistered.

Provider Information:

Agency Name: ____________________________________________
Agency Santrax ID: ______________________________ Provider Medicaid ID: ______________________________
Provider Phone number: ______________________________ Contact’s Name: ______________________________
Provider Address: _______________________________________________________________

Recipient Information:

Recipient Name: ____________________________________________ Replace □ or Return □
Reason for Replacement/Return: ______________________________
Serial Number: ______________________________ Recipient Medicaid ID#: ______________________________

Recipient Name: ____________________________________________ Replace □ or Return □
Reason for Replacement/Return: ______________________________
Serial Number: ______________________________ Recipient Medicaid ID#: ______________________________

Recipient Name: ____________________________________________ Replace □ or Return □
Reason for Replacement/Return: ______________________________
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