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) a 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: _____

Serial Number: _____ **Recipient Medicaid ID#:** _____

Recipient Name: _____ **Replace** ☐ **or Return** ☐
Reason for Replacement/Return: _____

Serial Number: _____ **Recipient Medicaid** ID#: _____