Rhode Island EOHHS FVV Device Replacement/Return Form

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

- Fill out and email to ricustomercare@sandata.com
- 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 SantraxID: _________________ Provider Phone Number:___________________________
Provider Medicaid ID:_____________ Contact's Name: __________________________________
Provider Address____

Recipient Information:

Recipient Name: ____
Replace _ or Return_ (Place an X to indicate Replace or Return)
Reason for Replacement/Return:____
Serial Number: ___________________________Recipient Medicaid ID #:________________________

Recipient Name: ____
Replace _ or Return_ (Place an X to indicate Replace or Return)
Reason for Replacement/Return:____
Serial Number: ___________________________Recipient Medicaid ID #:________________________

Recipient Name: ____
Replace _ or Return_ (Place an X to indicate Replace or Return)
Reason for Replacement/Return:____
Serial Number: ___________________________Recipient Medicaid ID #:________________________

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