

EQUIPMENT WARRANTY INFORMATION FORM

Date: _____

Beneficiary Name: _____

Provider Name: _____

Provider Address: _____

Every product sold or rented by our company carries a manufacturer's warranty. Your piece of equipment carries a _____ year warranty.

_____ will notify all Medicare and applicable Medicaid beneficiaries of the warranty coverage, and we will honor all warranties under applicable law.

_____ will repair or replace, free of charge, Medicare-covered equipment that is under warranty. This will also apply to Medicaid-covered equipment where required by state Medicaid regulations.

In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment if available.

I have been instructed and understand the warranty coverage on the product I have received.

Patient/Responsible Party Signature

Date