Rhode Island FVV Device Replacement/Return Form

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

- Fill out and fax it to **(401) 462-3350**.
- 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 #:** ______________