Standard and Supplemental Warranty Claim Form (US Only)

Complete and submit this form to request warranty credit for a Medtronic Restorative Therapies device or lead.

Warranty Type Requested (check either Standard Limited Warranty or applicable Supplemental Limited Warranty):

Standard Limited Warranty	Supplemental Limited Warranty
☐ Standard Limited Warranty	☐ Non-Prophylactic (physician claims lead/device was not functioning within normal tolerances) ☐ Prophylactic (physician medical judgment to replace lead/device that was functioning within normal tolerances)

Patient/Product Information:

Patient Name: _____

Hospital Medtronic Account Number: _____ Explanting Hospital Name: _____

Medtronic Employee Involved with the Case (if applicable): _____

Original Implant Date: _____ Date of Replacement Procedure: _____

Serial Number of Explanted Product: _____ Model Number of Explanted Product: _____

Serial Number of New Product: _____ Model Number of New Product: _____

Note: The Medtronic Warranty Claim Form and explanted product must be returned to Medtronic within 30 days of product explant, or as otherwise noted in the warranty terms. Please refer to the warranty documents included in the original product packaging for complete warranty terms and conditions.

Authorized Signatures:

Required for Standard and Supplemental Warranty Claims:

☐ By checking this box, you authorize the manufacturer to determine if a warranty credit is due. No warranty credit will be issued unless all requirements of the applicable warranty have been met. Warranties are for the benefit of the patient and any value received under a warranty should be credited to the patient's account. You may also be required to report the amounts received to the patient's payor, including Medicare. By checking this box, you represent that, after due inquiry, all of the information included is correct and you are authorized to sign on behalf of the hospital.

Name and Title of Authorized Representative of Medical Institution: _____

Initials of Authorized Representative of Medical Institution: _____

Email: _____ Telephone #: _____

Additional Signature as Required in Supplemental Limited Warranties:

☐ By checking this box, you represent that you have reviewed the applicable Supplemental Limited Warranty and agree to the Physician Confirmation Statement.

Physician Name: _____

Initials of Physician: _____

For questions, contact the Medtronic Warranty Hotline at (877) 359-6407 or rs.rtgwarranty@medtronic.com

Email Completed and Signed Warranty Claim Form to: rs.rtgwarranty@medtronic.com

Please send explanted products within 30 days of explant to:
Medtronic plc, Return Product Analysis RCC156
7000 Central Ave NE, Minneapolis, MN 55432 UC202014554EN

SUBMIT WARRANTY FORM