MCS Standard and Supplemental Warranty Claim Form (U.S. Only)

Complete and submit this form to request a warranty credit or a replacement for a component of the HeartWare™ HVAD™ System.

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

Standard Limited Warranty	Field Advisory Supplemental Limited Warranty
☐ Standard Warranty	☐ Non-Prophylactic (physician claims Product was not functioning within normal tolerances) ☐ Prophylactic (physician medical judgment to replace Product that was functioning within normal tolerances)

Patient/Product Information:

Medtronic Site Account Number: _____ Clinical Site Name: _____

Patient First Name: _____ Patient Last Name: _____

Pump Serial Number: _____ Medtronic Representative Who Supports Account: _____

Replacement Product Shipment Address

Address 1: _____ Address 2: _____

City/State/Zip: _____ Attention: _____

Product Allocation Date	Product Serial Number	Product Order Code	Product Malfunction Date	*Complete 2 fields below, if replacement product was provided to the patient*	
				Replacement Product Serial Number	*Replacement Product Allocation Date*

Note: Medtronic warranties require the Warranty Claim Form and affected Product to be returned to Medtronic at 14400 NW 60th Ave., Miami Lakes, FL 33014 within 30 days of the Product malfunction/replacement date. Please refer to the warranty documents for warranty terms and conditions.

Authorized Signature:

Required for Standard and Supplemental Warranty Claims:

☐ By checking this box or signing this form, you agree that you enable Medtronic to determine if a warranty credit or replacement product is due. No warranty credit or replacement product will be issued unless all eligibility criteria imposed by the applicable warranty have been met. Warranties for products possessed by patients are for the benefit of the patient and any value received under such 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 and entering your initials or signing this form, you represent, after due inquiry, that the product(s) noted on this form functioned in a manner inconsistent with its or their intended operation or performance, due to a defect in workmanship or materials under normal use in accordance with the HVAD™ System's Instructions for Use, all other warranty conditions have been or will be met, all of the above information is correct and you are authorized to sign on behalf of the clinical site.

Name and Title of Authorized Representative of Medical Institution: _____

Initials or Signature of Authorized Representative of Medical Institution: _____

E-mail: _____ Telephone #: _____

Additional Signature as Required in Supplemental Limited Warranties:

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

Physician Name: _____

Initials or Signature of Physician: _____

SUBMIT WARRANTY FORM

Within 30 days of the Product Malfunction/Replacement Date:

E-mail Completed Warranty Claim Form to: rs.mcswarranty@medtronic.com

Return product to: Medtronic 14400 NW 60th Ave., Miami Lakes, FL 33014

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

Pursuant to the HIPAA Privacy Rule (45 C.F.R. § 164.512(b)), covered entities may disclose protected health information without an authorization to a person or entity subject to FDA jurisdiction for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product.