ANZ VERSION:
October 2021

Medtronic Australasia Pty Ltd
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SYNTACTX

Valiant Navion™ Thoracic Stent Graft System
SAFE-N Limited Warranty Claim Form
Facility Graft Credit

Medtronic Site Account Number: _____ Clinical Site Name: _____

Patient First Name: _____ Patient Last Name: _____

Valiant Navion Serial Number: _____ Customer Facing Number (CFN): _____

Medtronic Representative Who Supports Account: _____

Date of Navion Implant	Date of Reintervention	Replacement Graft Type	If Valiant Captivia, Replacement Graft Serial Number
		☐ Valiant Captivia ☐ Other	

Authorized Signature:

_____

Required for Standard and Supplemental Warranty Claims:

☐ By checking this box or signing this form, you agree to allow Medtronic to determine if a warranty credit is due. No warranty credit will be issued unless all eligibility criteria imposed by the applicable warranty have been met. Additional limitations may apply. Reimbursements and credits are subject to review and approval. Warranties for product 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. Other payors may follow other rules, requiring you to contact them to confirm their process for reporting credits. By checking this box or signing this form, you attest that you have not already received or submitted for payment for the product used, or will correct or remit payment received or submitted for the product. 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, or that you determined in the exercise of independent medical judgment that reintervention was warranted. All other warranty conditions have been 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 Number: _____

Within 90 days of the Reintervention Date:
E-mail Completed Warranty Form to: SAFE-N-Reimburse@syntactx.com

Mailing or facsimile submission is also available at:
Syntactx
RE: SAFE-N Project
4 World Trade Center
150 Greenwich Street, 44th Floor
New York, New York, 10007
or
Facsimile: **1 (800) 342-1401**

Please allow between 45-60 days for processing any reimbursement request. Syntactx may need to contact you directly to obtain additional verification or information before payment may be processed. Please consult your financial and tax advisor regarding any reporting obligation for tax purposes.

For questions, contact Medtronic through Syntactx:

SAFE-N reimbursement helpline: AU: 1800 512 149, NZ: 0800 444 248

Email: SAFE-N-Reimburse@syntactx.com

You may also visit NavionSafety.syntactx.com/aus or NavionSafety.syntactx.com/nzl