ROSA® Advantage Warranty Claim Form

Please note: Claim Form must be returned within 30 days of revision surgery.

Hospital Name

Customer Account Number

Street Address

Address Line 2

City

State

Postal/Zip Code

Please indicate if the facility making the claim is the:

Implanting Hospital Revision Hospital Both

Surgeon Name

First Last Suffix NPI #

Patient Name

Title First Last Suffix

Street Address

Address Line 2

City

State

Postal/Zip Code

Date of Birth

/ /

MM DD YYYY

Original Surgery Date

/ /

MM DD YYYY

Revision Surgery Date

/ /

MM DD YYYY

Gender

Male Female

Return product within 2 days of surgery. If unable to do so, please provide rationale below.

Zimmer Biomet will contact you w/CMP & RGA #

SMS Case number and SMS Case number for the revision

Reason for Revision:

*Attach invoice of original surgery or sticker sheet of op notes from original surgery.

Revision Implant Sticker(s)

Ref # Lot #

Ref # Lot #

Original Persona Knee Implant Left Knee Right Knee

Zimmer Biomet Representative Name (Printed)

Zimmer Biomet Representative Signature

Date: / /

MM DD YYYY Distributor

Part 1 — Patient Chart Hospital
Part 2 — Zimmer Biomet Customer Operations
Part 3 — Surgeon

Click Here to Submit to Zimmer Biomet Customer Service