



Equipment Write-Off Request Form F-100A

Work Order #: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Funding Source(s): \_\_\_\_\_

Margin of the order with full reimbursement: \_\_\_\_\_

Margin of the order with requested reimbursement: \_\_\_\_\_

Order Amount: \_\_\_\_\_ Write-Off Amount: \_\_\_\_\_

Total cost of equipment considered for write-off: \_\_\_\_\_

Pre-Delivery Request

Post Delivery Request

Equipment Requested for Write Off:

Detailed reason(s) for request including explanation of previous actions taken to secure funding and/or why funding cannot be secured: (If requesting a Hardship, please use the Financial Hardship Application Form)

Requested by: \_\_\_\_\_ Date: \_\_\_\_\_

All fields above must be completed prior to submission to the appropriate approval party outlined below.

Reviewers Notes:

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

Approval Thresholds: (Pricing Based on Expected Reimbursement Amounts)

Pre-Delivery

\$0-\$1,000 - Regional Area Director

\$1,000 or above - Division Vice President

Post-Delivery (MIR)

\$0 - \$5,000 – Funding Supervisor

\$5,000 or above - Funding Director/Manager