synapse HEALTH

Network Policy Updates

Effective June 1, 2026

Frequently Asked Questions – Network Policy Updates

The following questions address common inquiries related to the policy updates communicated in our May 18, 2026 provider notice. If your question is not addressed below, please contact your account representative or reach us at dmeprovidersupport@synapsehealth.com

When do these policy changes take effect and does the 60-day timely filing rule apply retroactively to dates of service before June 1, or only to new dates of service going forward?

A: The updated policies take effect June 1, 2026. All claims must be submitted within 60 days of the date of service. This applies to all claims going forward.

Q: Who determines the "date of service"?

A: Ship date for most mail order and Delivery date for threshold (live deliveries within the home or branch)?

Q: How does the new 30-day invoice reconciliation window work?

A: Synapse will continue issuing monthly invoices covering the prior month's order activity. Once you receive a statement, you have 30 days to submit the reconciliation. Only dates of service within the prior 60 days of that invoice will be considered during reconciliation. Claims falling outside this window will not be considered, so it is important to review and respond to statements promptly upon receipt.

Q: Where are my monthly invoices and how do I submit a reconciliation?

A: Your assigned Statement Analyst will upload your monthly statement to your Accounts Receivable & Invoices ShareFile folder no later than the 25th of each month. Complete the Payment Reconciliation tab included in your statement. Ensure all fields are completed prior to submission. If the reconciliation file is missing any critical information including full name, date of birth, policy number, date of service(s), HCPCS, and quantity will be denied.

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Q: What are the three criteria required for a member transition to be considered complete and payable?

A: For all patients transitioning to Synapse Health as the provider of record on or after June 1, the following three criteria must all be satisfied:

1. An up-to-date prescription that meets Medicare guidelines .
2. A delivery ticket that meets Medicare proof of delivery requirements which itemizes all products expected to be reimbursed.
3. Successful patient contact by Synapse Health confirming the patient's use and continued need for DME.

All three must be met before Synapse will process payment for transition invoices.

Q: What happens if Synapse Health is unable to reach the patient after the transition?

A: If Synapse Health cannot establish contact after four documented attempts, the transition will be placed on hold and the order will be cancelled with a status flag in the system. If the patient later calls in on their own, the transition will proceed immediately. Payment will not be issued unless and until patient contact is confirmed — however, retroactive payment will apply back up to 60 days from the date of inbound contact.

Q: The notice mentions warm transferring patients to Synapse Health if they call our office — what number should we transfer them to?

A: Synapse Health runs a structured outreach campaign for each transition cohort, making at least four documented contact attempts per member across multiple channels — phone, email, text, and/or letter over the course of 30 days. All contact activity is logged with timestamps, and weekly audit-ready reporting is available for supplier review, including contact status, attempt logs, and transition disposition.

Q: Will we receive a new Master Services Agreement to sign?

A: Yes. A new Master Services Agreement (MSA) will be circulated to all providers in the network. The updated agreement establishes a clear framework defining responsibilities for both Synapse Health and its subcontractors. These expectations will take affect even without the MSA execution.