DME Provider Fax Cover Sheet



Use this form to submit fax orders for Home Medical Equipment. For expedited processes, enter your orders electronically at connect.synapsehealth.com.

0	Synapse Health Fax: (Hospital/STAT orders): 1.888.518.4433 - (Outp					rders): 1.888.690.5329				
	# of pages	Date								
Σ	DME Provider Details									
FROM	Provider Name	Contact Name								
	Phone	Fax								
	Email				Time Zone					
	Date Needed/ Date of Discharge									
Check all that apply: Order type: Hospital Discharge Hospital fax# 888.690.5329 Resupply New Resupply Existing New Order Pre-Op Member Plan Change Order urgency: Urgent Standard Order Already Dispensed Notes:										
	se check all documents include Prescriber Signed RX Following is required to start t	Delivery Pa For Already Di	spensed Items		Supporting Documents					
	nt orders missing any of the below ma		- The poor round in							
Pati Nar			Patient Date of Birth							
Pati Add	ent Iress		Patient Phone No.							
	irance irmation		Primary Policy Holder							
Plan Name, ID Number, & Group Number Name, DOB, & Relationship to Patient										
1	1.888.33.MYDME (1.888.336.	.9363)			SYNABSEHEALTH COM					

8AM - 8PM (Eastern Standard Time)

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ICD 10 Dia	gnosis Codes (at l	east one required).						
					11			
Primary								
All fields requ	uired.							
HCPCS	Description		# c	of Units	Delivery (Y/N)	Date Delivered	Request Delivered	
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)				
Prescriber	Information:							
Prescriber Name				NPI				
Phone					Primar	V		
Number E:		t. Contact						
Clinic			Clinic					
Name				Addre	ess			
Email								