

Payment Reconciliation Form



Please select from the reasons listed, collect all required documentation and email (secured) to Synapse Health Accounting at ap@synapsehealth.com. Upon review, Synapse Health will communicate back via email to the Provider within seven (7) business days.

Reason for form submission (check all that apply):

- Overpayment:** Synapse Health paid for an item that was not delivered by the provider or the payment issued by Synapse Health was over the contracted amount for an item/service.
- Underpayment:** Synapse Health paid less than the contracted amount for an item/service completed by the provider.
- Missed Payment:** Synapse Health did not reimburse for an item/service that was delivered to a patient by the provider.

Please submit the below documentation for each overpayment, underpayment and/or missed payment.

1. Invoice number, date, due date per contract
2. Patient name and 'Ship To' address
3. Prescription number & date
4. Billable quantity, pack size & unit of measure
5. Sales tax (if applicable)
6. Shipping & handling (if applicable)
7. Standard product code and agreed upon product description
8. Type of service—Rental or New Equipment
9. Supporting document/information (i.e., tracking numbers for mail orders)

Provider Name

Contact Name

Contact Phone

Contact Email