

Fax Cover Sheet



Use this form to submit requests for Home Medical Equipment.

To expedite, please enter your orders electronically at connect.synapsehealth.com.

To: Synapse Health Fax Hospital Discharge/Urgent orders to **1.888.518.4433** | Outpatient orders to **1.888.690.5329**

of pages: _____ Order Date: _____ Date of Discharge: _____
(if applicable)

DME Provider Information

Business Name: _____ Contact Name: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____ Zip Code: _____

Email: _____ Time Zone: _____

Check all that apply:

Order urgency: Urgent Standard Already Delivered

Order type: Hospital Discharge Resupply New Order

Pre-Op Insurance Plan Change

Notes:

Please check all documents included in fax:

Prescriber Signed Rx Delivery Paperwork For Already Delivered Items Supporting Documents (Ex: Face-to-Face, H&P, etc.)

The following patient information is REQUIRED to start the order process with Synapse Health:

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Insurance Information: _____

(Plan Name, ID Number, & Group Number)

Primary Policy Holder Information: _____

(Name, DOB, & Relationship to Patient)

1.888.33.MYDME (1.888.336.9363) | 8 AM—8 PM EST

synapsehealth.com

NOTE: This transmission contains confidential information belonging to the sender that is legally privileged and proprietary and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding, or saving them.

Fax Cover Sheet



ICD-10 Diagnosis Codes (at least one required)

--	--	--	--	--	--

Product Information (all fields with * are required)

HCPCS*	Description*	Qty*	Delivered? (Y/N)*	If Yes, Date Delivered	If No, Requested Delivery Date

Prescriber Information:

Name: _____ NPI: _____

Phone Number: _____ Ext. _____ Primary Contact Name: _____

Facility Name: _____ Facility Address: _____

(if applicable)

Email: _____

Fax Hospital Discharge/Urgent orders to **1.888.518.4433** | Outpatient orders to **1.888.690.5329**

Phone: **1.888.33.MYDME (1.888.336.9363) | 8 AM—8 PM EST**

synapsehealth.com

NOTE: This transmission contains confidential information belonging to the sender that is legally privileged and proprietary and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding, or saving them.