Fax Cover Sheet

synapse HEALTH

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)

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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:

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