Order Cover Sheet

Use this form to submit requests for Home Medical Equipment.

Fax Hospital/Urgent orders to 1.888.518.4433 | Outpatient orders to 1.888.690.5329
Email to: neworder@synapsehealth.com

# of pages:

Order Date:

Prescriber Information

Hospital/ Outpatient Facility Name:

Contact Name:

Phone:

Fax:

Time Zone:

Email:

Date Needed/ Date of Discharge:

Check all that apply:

Order urgency: ☐ Urgent ☐ Standard Order

Order type: ☐ Hospital Discharge ☐ Resupply ☐ New Order ☐ Pre-Op ☐ Insurance Plan Change

Please check all documents included:

☐ Prescriber Signed Rx ☐ Face-to-Face Notes ☐ Supporting Medical Record Documentation (i.e. Chart notes, required testing)

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

Name:

Date of Birth:

Address:

Phone No.

Insurance Information:

(Plan Name, ID Number, & Group Number)

Primary Policy Holder Information:

(Name, DOB, & Relationship to Patient)

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