

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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