300 Artino Street, Oberlin, Ohio 44074

Patient Insurance Information
NeuRx DPS® Kits

Patient Information: Complete the following section or **attach the patient's face sheet.**

Patient Name: Last__________________________________ First_________________________________ M.I.____________

Patient Phone:____

Alternate Contact Name:____

Phone:_____________________________

Address:____

City:______________________________________ State:________________________ ZIP:______________________

Insurance Information:

Primary Insurance:___________________________________

Phone:____

Policyholder:____ ID#:____

Employer or Group Name:____________________________ Group #:____

Secondary Insurance:________________________________

Phone:____

Policyholder:_____________________________________ ID #:_____________________ Group #:_____________________

Hospital Information:

Hospital:____

Placement Date:_____________________________________ Discharge Date:_____________________________________

Name of NeuRx DPS® Contact at Physician's Office:____

Name of Referring Physician:____

Patient Care: Complete this section. If applicable, may reduce patient's supply cost.

Care Start Date:____________________________________

Name of Provider:____ Provider Contact:___________________________________

Phone:____

Complete insurance information is critical for timely shipment of supplies

Patient is being discharged to:

- ☐ Home with no nurse in home
- ☐ Nurse in home (HHA/VNA)
- ☐ Hospice
- ☐ Skilled Nursing Facility (SNF)

Please fax completed forms to: 877.307.6350

I would like confirmation the prescription was received. Contact me via;
Phone: ________________________________ or E-Mail: ____

Preserve original order or mail to:

Attn: Kelly Cramer
Edgepark Medical Supplies
1810 Summit Commerce Park
Twinsburg, OH 44087
1-866-528-2142 ext 3582 or Fax# 330-963-6172
kellyc@edgepark.com

Questions? Call the Synapse Biomedical Customer Service: 1-888-767-3770

Notes: ____

This prescription or the information contained herein may be shared with or reported to Synapse Biomedical Inc, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients using the NeuRx DPS® product line. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with Synapse Biomedical Inc., please call 877-307-8033 and a NeuRx DPS® Specialist at Edgepark Medical Supplies will assist with this request and ensure that the information is not shared.

Synapse Biomedical or authorized representative (Edgepark Medical Supplies)
NeuRx DPS® is a trademark and/or registered trademark of Synapse Biomedical Corporation.

Detailed Written Order NeuRx DPS®

Section A:

Patient Name:____ D.O.B.:___________________

Sex:______M_______F Phone:_______________________

Patient Address:____

City:____ State:______________________ ZIP:_______________________

Physician:____Phone:_________________________

_

Physician Address:____

City:____ State:_________________________ ZIP:____________________

Section B: Please Review and/or Complete

Primary Diagnosis — (required)

Diagnosis (ICD-9) Please Check Appropriate Diagnosis:

ICD-9-CM Code	Description
☐ 344.01	Quadriplegia, c1-c4 complete
☐ 344.02	Quadriplegia, c1-c4 incomplete
☐ 518.82	Other Pulmonary Insufficiency
☐ 518.83	Chronic respiratory failure
☐ 335.20	Amyotrophic lateral sclerosis
☐ 519.4	Disorders of diaphragm
☐ ______ (code)	____ (Description)

Secondary Diagnosis — (required)

ICD-9-CM Code	Description
☐ 344.09	Other quadriplegia and quadriparesis
☐ 507.0	Pneumonitis due to solids and liquids
☐ 786.09	Other respiratory distress, insufficiency

Length of Need (Months): 12 months

- ☐ Synapse Biomedical Part # 22-0020 Batteries (3 per Pack) – 7 Packs per Year
- ☐ Synapse Biomedical Part # 22-0011 Patient Cable – 6 per year
- ☐ Synapse Biomedical Part # 22-0004 Connector Holder (1 pack = 30 bandages) – 14 packs per year

Section C: Physician Attestation

I certify that I am the physician identified on this form. I have reviewed all sections of the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and Physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical records.

Please Sign Here Prescriber's

Signature____ Date______/______/______

UPIN:______________________ NPI #:______________________________

Fax completed forms to 330-963-6172

Note that incomplete or incorrect forms may experience a delay in processing.