Prescription Request Form (DME)

Synchrony Functional Electrical Stimulation System

I am interested in exploring **Synchrony by Synapse Biomedical Inc.**, a rehabilitation system that allows the patient to actively participate in therapy by using their stronger hand to help control stimulation to the affected hand during functional activities. Please evaluate whether this may be appropriate for my condition and overall treatment plan.

Patient Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Prescribing Physician

Physician Name: _____

NPI: _____ Credentials: _____

Phone: _____ Fax: _____

Clinical Information

Date of Last Visit: _____

Date of Onset: _____

ICD-10 Diagnosis Codes (check all that apply)

☐ I63.9 – Cerebral infarction, unspecified

☐ I69.351 – Hemiplegia, right dominant side

☐ I69.352 – Hemiplegia, left dominant side

☐ I69.353 – Hemiplegia, bilateral

☐ I69.331 – Monoplegia upper limb, right dominant

☐ I69.332 – Monoplegia upper limb, left dominant

☐ M62.81 – Muscle weakness

☐ R27.9 – Lack of coordination

☐ R29.898 – Other neurologic/musculoskeletal symptoms

☐ Other: _____

HCPCS Codes

☐ L9900 - Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code

☐ L8699 - Prosthetic implant, not otherwise specified

☐ L7499 - Upper extremity prosthesis, not otherwise specified

www.synapsebiomedical.com | 888-767-3770 | 300 Artino Street, Oberlin, Ohio 44074

☐ E1399 - Durable medical equipment, miscellaneous
☐ A9999 - Miscellaneous DME supply or accessory, not otherwise specified
☐ A9900 - Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
☐ Other: _____

Order Details
Device: Synchrony Patient Kit – PN: 20-3002
Length of Need: ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 99 mo
Frequency: ☐ Daily ☐ 3x/week ☐ Per therapy plan

Medical Necessity
The prescribed device is part of a rehabilitation program based on clinician evaluation. The patient presents with neuromuscular impairment requiring therapeutic intervention.

Physician Authorization
Signature: _____
Printed Name: _____
Date: _____

FAX OR EMAIL THIS PRESCRIPTION TO SYNAPSE DME FOR FULFILLMENT
FAX: 440-774-2572
EMAIL: INFO@SYNAPSEDME.COM

www.synapsebiomedical.com | 888-767-3770 | 300 Artino Street, Oberlin, Ohio 44074