MEDICAID/CHIP PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM

PERM REQUEST FOR RECORDS *COVER SHEET*

PERM-ID:

Date:

Patient Name:	**Provider Number:**
Date of Birth:	**Provider Name:**
Recipient ID:	
Date(s) of Service:	
Category 16: Durable Medical Equipment (DME) and supplies, Prosthetic / Orthopedic devices	
Record Submission Due Date:	

Please submit all *applicable* documents, for the requested **date(s) of service,** from the listing below as well as any other supporting documentation your state may require your facility to keep.

Durable Medical Equipment (DME) and supplies, Prosthetic / Orthopedic devices, and Environmental Modifications:

Physician Orders (*signed and dated*)

DME / Supplies Prescription (*signed and dated*)

Prosthetic Device Assessments / Notes (*dated*)

Invoice for Services

Proof of Delivery / Signature Logs

Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*

Please review the **Instructions for Submitting Requested Record/Documentation**, included in this packet, before submitting documentation. Documents **must be** submitted with this **PERM Cover Sheet** as the first page. The PERM Review Contractor office uses this sheet to confirm receipt of your documents.

A+ Government Solutions, Inc.
PERM Review Contractor