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 7: Dental and Oral Surgery Services	
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.

Dental and Oral Surgery Services:

Dental Chart

Dental Visit Clinical Notes (*signed*)

Dental Plan of Care

Dental History

Dental X-Rays Notes (*please **do not** send x-rays*)

Procedure Record / Notes

Prior Authorization *(if required)*

Note: Clinical documentation (notes, plan of care, etc.) issued from electronic records must be signed and dated.

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