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 9: Home Health 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.

Home Health Services

Physician Certification / Recertification / Form 485 Plan of Care

Physician Orders (*signed and dated; **include all physician orders relevant to the sampled claim***)

Initial / Intake Assessment

Nursing Assessments and Notes

Nursing Care Plan

Home Health Aide Notes / Worksheets (*time in and out*)

Physical Therapy (PT) Assessments (*time in and out*)

Occupational Therapy (OT) Assessments (*time in and out*)

Speech Language Pathology (SLP) Assessments (*time in and out*)

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

Infusion Therapy (*time in and out*)

DME Prescription (*signed and dated*)

DME Signature Log / Proof of Delivery

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.