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 11: Hospice 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.

Hospice Services *(services provided at home, nursing facility, hospital, hospice facility)*:

Admission Face Sheet

Physician Certification / Recertification
(*signed and dated;* ***include cert/recert done prior to date(s) of service if not completed during requested time frame***)

Hospice Benefit Election / Revocation Forms

Initial / Intake Assessment

Hospice Nurse Visit and Progress Notes

Multidisciplinary Care Plan and Notes

Volunteer Notes

Social Work Notes

Spiritual Notes

Nutrition / Dietary Notes

Home Health Aide Notes / Worksheets

Medication Administration Record (MAR)

Facility Verification of Daily Presence

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.