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 4: Intermediate Care Facilities (ICF) for Persons with Mental Retardation (ICF/MR) and ICF/Group	
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.

Intermediate Care Facilities (ICF) for Persons with Mental Retardation (ICF/MR) and ICF/Group Homes:

- 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***)
- Physician Orders (*signed and dated; **include all physician orders relevant to sampled claim***)
- Progress Notes for All Disciplines / Departments
- Nursing Notes & Flowsheets
- Nursing Assessment
- Minimum Data Set (MDS) *Applicable to date(s) of service (signed)*
- Resident Assessment Protocol (RAP)
- Medication Administration Record (MAR)
- Treatment Administration Record / Notes
- Documentation of Daily Patient Presence
- All Transfer Forms
- Leave of Absence Documentation

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