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 1: Inpatient Hospital 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.

Inpatient Hospital Services

- **Short Term Inpatient Acute Care**
- **Long Term Acute Facilities**
- **Rehabilitation Inpatient Care**

Admission Face Sheet / Coding Summary
Physician Coding Query Forms
Emergency Department Record / Notes
ER Admit Note
Admission History and Physical (H&P)
Physician Orders (*signed*)
Progress and Nursing Notes
Case Management Plan / Notes
Nursing Assessment
Nutrition / Dietary Assessment
Consultation Reports / Notes
Cardiovascular and Respiratory Reports
Physical Therapy (PT) Assessments / Notes
Occupational Therapy (OT) Assessments / Notes
Speech Language Pathology (SLP) Assessments / Notes
Medication Administration Record (MAR)
Treatment Administration Record / Notes
Vital Sign Flowsheets
Intake and Output (I&O)
Dialysis Record / Notes
Operative and Procedure Reports / Notes
Anesthesia Record (Pre and Post-Op)
Perioperative Record / Notes
Laboratory and Diagnostic Tests / Reports
Labor and Delivery Record / Notes
Discharge Summary
All Transfer Forms
Itemized billing sheet (*If required based on payment method*)

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