**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 14:** Laboratory, X-ray and Imaging Services | |
| **Record Submission Due Date:** 08/15/2011 | |

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.

**Laboratory, X-ray and Imaging Services:**

Physician Order Sheet *(signed and dated)*

X-Ray / Imaging Report/Results (*please **do not** send x-rays*)

Lab Reports Results

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**