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 3: Nursing Facility, Chronic Care Services & Intermediate Care Facilities (ICF)

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.

Nursing Facility, Chronic Care Services & Intermediate Care Facilities (ICF):

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 dates of service time frame (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