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 5: Outpatient 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.

Outpatient Hospital Services:

Outpatient / Clinic Face Sheet

Encounter / Clinic Visit Record / Notes

Evaluation and Management (E&M) / Counseling Notes

Treatment Plan

Ambulance Record

Emergency Department Record / Notes

Related Laboratory / Diagnostic Reports

Physician Orders (*signed*)

Anesthesia Record

Cardiovascular and Respiratory Reports

Dialysis Treatment Record / Notes

Operative / Procedure Record and Notes

Perioperative Record and Notes

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.