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 6: Physician Clinic Services / Physicians & Other Licensed Practitioners' 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.

Physician Clinic Services

Clinic Face Sheet

Encounter / Office Visit Record / Notes

Evaluation and Management (E&M) / Counseling Notes

Related Laboratory / Diagnostic Reports

Treatment Plan

Procedure Record / Notes

Immunization Record

Dialysis Treatment Records and Notes

Patient Education Documentation

Prior Authorization (if required)

Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*

Physicians & Other Licensed Practitioners' Services

Encounter / Office Visit / Clinic Record and Notes

Evaluation and Management (E&M) / Counseling Notes

Related Testing / Evaluations and Reports

Treatment Plan

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.

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PERM Review Contractor