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 8: Prescribed Drugs	
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.

Prescribed Drugs:

Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form:

Front and Back (*if applicable*)—with patient name, date of birth, address, telephone number and physician name

Member Profile with Refill History

DEA Number for Controlled Substances

Physician Medication Order for Skilled Nursing Facility (SNF) / Nursing Facility (NF) or Intermediate Care Facility (ICF) for Persons with Mental Retardation (ICF/MR) (*signed*)

Prior Authorization (*if required*)

NDC Number

Member Pharmacy Signature Log / Proof of Delivery

Proof of Delivery to Nursing Home

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.