**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 12:** Therapies, Hearing, and Rehabilitation 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.

**Therapies, Hearing, and Rehabilitation Services**

- **Therapies: Physical, Occupational, and Respiratory**
- **Services for Speech, Hearing, and Language Disorders**
- **Necessary Supplies and Equipment**

Physician Orders (*signed and dated;* ***include all physician orders relevant to sampled claim***)

PT, OT, SLP, and Respiratory Therapy (RT): Evaluation and Re-evaluation / Notes

*(with start & stop times)*

DME Prior Authorization (*if required*)

DME Signature Log / Proof of Delivery

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

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**