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 17: Transportation and Accommodations	
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.

Transportation and Accommodations:

Transportation Schedule for Requested DOS (*as applicable*)

Starting Point and Destination / Odometer Readings

Transportation Log with Member Signature

Physician Order for Transportation *(accommodations, if applicable)*

Documentation reflecting Medical Necessity for Transportation *(accommodations, if applicable)*

Transportation Provider's Account Ledger

Billing Statements

Ground Mileage / Air Mileage Details

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.