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 15: Vision: Ophthalmology, Optometry, and Optical 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.

Vision: Ophthalmology, Optometry, and Optical Services:

Ophthalmology Visit and Progress Notes *(signed and dated)*

Optometrist Orders *(signed and dated)*

Optometry and Optical Visit Notes *(signed and dated)*

Physician Orders *(signed and dated)*

Diagnostic Test Results

Eyeglass / Optician Invoices

Proof of Delivery / Signature Logs

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