

MEDICAID/SCHIP PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM COVER SHEET

Perm Database and Documentation Contractor

Medicaid/SCHIP Provider:

Report Date:

Beneficiary Name: Sampling Unit ID: Provider Number: Service From/To: CID Number: State: Category: 4
Letter Sequence:

Please submit ALL **APPLICABLE** documents from the **Appropriate** Listing below and ANY **ADDITIONAL** documentation to support your Medicaid/SCHIP claim for services provided on the Date(s) of Service requested.

If your individual State's Medicaid/SCHIP policy requires you to maintain specific documentation related to the type of services you provide, please also include those in your submission.

Physicians' Services:

Encounter/Office visit record/notes	Treatment Plan	Number of units billed with unit definition
E&M/counseling notes	Treatment consent form	(such as, 15 minutes, 30 minutes, one hour,
Related Laboratory/Diagnostic reports	Procedure record/notes	1 visit, etc..)

Nurse Practitioner:

Encounter/Office visit record/notes	Treatment Plan	Physician documentation
E&M/counseling notes	Treatment consent form	
Related Laboratory/Diagnostic reports	Procedure record/notes	

Other Licensed Practitioners' Services:

Encounter/Office visit record/notes	Treatment Plan	Prior Authorization, if required
E&M/counseling notes	Treatment consent form	Related testing / evaluations and reports
Related Laboratory/Diagnostic reports	Procedure record/notes	

Outpatient Hospital Services:

Outpatient/Clinic Face Sheet	Treatment Plan	Perioperative record/notes
Encounter/visit record/notes	Treatment consent form	Anesthesia record
E&M/counseling notes	Operative record/notes	Beneficiary ESRD Election form
Ambulance record	Procedure record/notes	Dialysis Treatment Records/notes
Emergency Department record/notes	Cardiovascular Reports	Prior Authorization, if required
Related Laboratory/Diagnostic reports	Respiratory Reports	Patient Education Documentation

Clinic Services:

Clinic Face Sheet	Treatment Plan	Patient Education Documentation
Encounter/visit record/notes	Treatment consent form	Beneficiary ESRD Election form
E&M/counseling notes	Procedure record/notes	Dialysis Treatment Records/notes
Related Laboratory/Diagnostic reports	Immunization record	Prior Authorization, if required

Please:

- Copy both sides of each page.
- DO NOT cut off page edges when copying.
- If you need to send additional information later, DO NOT re-send documents you have already sent. Only send the additional documentation with the identifying cover sheet.

Documents **must be** submitted with this original bar coded cover sheet. The PERM Database and Documentation Office uses this sheet to confirm receipt of your documents.

Please fax documentation to **(240) 568-9122**. If unable to fax documents, please send the documents to the address below:

PERM Database and Documentation Contractor

Attn: CID# _____

9090 Junction Drive, Suite 9

Annapolis Junction, Maryland 20701

checklistperm_4outhospracclinic_082007.pdf