

**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: 6
Letter Sequence:

Please submit ALL **APPLICABLE** documents from the 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.

Prescribed Drugs:

Copy of Prescription: Original, facsimile or telephonic
Physician medication order for SNF/NF or ICF/MR
Prescription Label and Patient information
NDC Number
DEA Number for controlled substances
Prior Authorization, if required
Member pharmacy signature log / proof of delivery
Proof of Delivery to Nursing Home
Nursing Home Pharmacist Drug regimen review

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

PrescribedDrugs6_020808.pdf

