

MEDICAID/SCHIP PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM

COVER SHEET

PERM Database and Documentation Contractor

Medicaid/SCHIP Provider:

Report Date:

Patient Name:
Sampling Unit ID:
Provider Number:
Service From/To:
CID Number:
State: Category:



Letter Sequence:

DUE DATE:

Please submit ALL **APPLICABLE** documents from the Listing below and ANY **ADDITIONAL** documentation to support your Medicaid 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.

LIST of REQUESTED DOCUMENTATION
By Category Type

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