Fax

Provider: [|||ProviderName|]]	Medical Record Contact: [|||ContactName|]]
Fax: [|||ContactFaxNo|]]	**Pages: 5, including this page**
Phone: [|||ContactPhoneNo|]]	**Date:** [|||MRReSubDate|]]
Re: Letter of request for medical record on PERM ID: [|||PermID|]]	

Note:

Attached is a request for medical records under the Payment Error Rate Measurement (PERM) program. Please process this request as soon as possible. If you have questions, please call our Customer Service Representatives at (301) 987-1100.

PERM – INITIAL REQUEST FOR RECORDS

Date: [||RequestDate||]

[||ProviderName||]
ATTN: [||ContactName||], [||ContactTitle||]
[||ContactAddress1||] [||ContactAddress2||]
[||ContactCity||], [||ContactState||] [||ContactZipcode||]

Reference ID: [||PERM ID||]
OMB Control Number: [||OMB#||]
NPI: [||NPI#||]

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1] program. Additional information about the PERM program is addressed on the CMS PERM website (www.cms.gov/PERM). Refer to the "Providers" link on the website.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program by CMS' review contractor, CNI Advantage, LLC.

Action: A Copy of Original Documentation Required: Federal regulations require that you provide the medical record documentation to support claims for Medicaid/CHIP services upon request. The pages that follow provide identifying information for the claim selected for review, requested documentation, and submission instructions. Please submit documentation as soon as possible, but no later than the due date shown above. A response is required by the due date even if you are unable to locate requested documents. Providing medical records for Medicaid/CHIP patients does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. CMS and its contractors will comply with the Privacy Act and regulations.

When: [||MedrecDueDate||]
Please provide the requested documentation by [||MedrecDueDate||]. A response is still required by [||MedrecDueDate||] even if you are unable to locate the requested information.

Consequences: If you fail to deliver the requested documentation or contact us by [||MedrecDueDate||], your state agency may pursue recovery of payment for this claim.

Instructions: The pages that follow provide identifying information for the claim selected for review, requested documentation, and submission instructions. Should you require additional information or have questions, please call our Customer Service Representatives at (301) 987-1100, the Records Manager, Bahar Degirmencioglu, at (301) 987-1107, or your state PERM representative, _____, at _____.

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[1] Social Security Act Section 2107(b)(1) [42 CFR §431.950 et seq]; 45 CFR parts 160 and 164

Payment Error Rate Measurement (PERM)
REQUEST FOR RECORDS COVER SHEET
PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Patient Name: [||BeneficiaryName||]	**Provider Number:** [||ProviderID||]
Date of Birth: [||BeneficiaryDOB||]	**Provider Name:** [||ProviderName||]
Beneficiary ID: [||BeneficiaryID||]	
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]	
Category 1: Inpatient Hospital Services	
Record Submission Due Date: [||MedrecDueDate||]	

Please indicate # of pages in submission:

_____ pages

Inpatient Hospital Services: Acute Inpatient, Long-Term Acute, Acute Inpatient Rehabilitation

Please submit all *applicable* documents from the listing below to support the claim sampled.

- **Admission History and Physical** *(H&P)*
- **Physician Orders and Progress Notes (*signed and dated*)**
- **Medication Administration Record** *(MAR)*
- **Discharge Summary**
- Admission Face Sheet/Coding Summary
- Emergency Department Record and Admission Order/Notes
- Nursing Assessment/Notes
- Consultation Reports/Notes
- Cardiovascular and Respiratory Reports
- Itemized Billing Sheet (*if required based on payment method*)
- Ambulance Services
- Dialysis Treatment Record/Notes
- Operative and Procedure Reports/Notes
- Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes *(with start and stop times)*
- Laboratory and Diagnostic Tests/Reports
- Labor and Delivery Record/Notes
- All Transfer Forms
- Physical Therapy: Evaluation/Re-evaluation/Notes
- Speech Language Pathology: Evaluation/Re-evaluation/Notes
- Occupational Therapy: Evaluation/Re-evaluation/Notes

> *Note: The documents that are bolded are frequently required documents for this category and service type. Please include in document submission if applicable to sampled claim.*

Please help ensure accurate processing by placing this page on top of the records you are submitting.

Payment Error Rate Measurement (PERM)
Claim Summary

Provider Number: [||ProviderID||]   Request Date: [||MRReSubDate||]
Beneficiary/Patient Name: [||BeneficiaryName||]   PERM-ID: [||PermID||]
Beneficiary ID: [||BeneficiaryID||]   Claim Category: [||ClaimCatNum||]
Date of Birth: [||BeneficiaryDOB||]   State Claim ID: [||StateClaimID||]
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]   DUE DATE: [||MedrecDueDate||]

Diagnosis Code	Procedure Code	NDC Code	Rx Number	DRG	Amount Paid
[||Diag1||]	[||Proc1||]	[||NdcCode1||]	[||RxNumber1||]	[||Drg||]	[||PaidAmt||]
[||Diag2||]	[||Proc2||]	[||NdcCode2||]			
[||Diag3||]	[||Proc3||]	[||NdcCode3||]			
[||Diag4||]	[||Proc4||]	[||NdcCode4||]			
[||Diag5||]	[||Proc5||]	[||NdcCode5||]			
[||Diag6||]	[||Proc6||]	[||NdcCode6||]			
[||Diag7||]	[||Proc7||]	[||NdcCode7||]			
[||Diag8||]	[||Proc8||]	[||NdcCode8||]			
[||Diag9||]	[||Proc9||]	[||NdcCode9||]			

Provider's Checklist

❑ PERM Cover Sheet is first page of your submission

❑ Correct recipient

❑ Correct date(s) of service

❑ Every page of your submission is readable

Payment Error Rate Measurement (PERM)
Instructions for Submitting Requested Record/Documentation

Please choose ONE of the following methods for submitting records/documentation:

1. Electronic Submission of Medical Documentation (esMD)

Providers are encouraged to submit requested medical documentation via the **Electronic Submission of Medical Documentation (esMD).** Information pertaining to esMD is available at https://www.cms.gov/esMD

2. Fax

1. Place PERM Cover Sheet on top of each record submission.
2. If your facility has *more* than one PERM request, please fax each record separately.
3. Fax documents to one of the following numbers:

1-301-417-8040

or

1-877-619-7850

3. Mail

1. Place PERM Cover Sheet on top of each record submission.
2. All documents must be complete and legible.
3. Please do not staple or paper clip any pages together.
4. If you choose to send the documentation on USB Flash Drive/CD/DVD, the file(s) must be *encrypted*. Please submit the password via email to Encryption@permrc.com and include the PERM ID in the subject line. **Please note that USB flash drives cannot be returned to providers.**
5. Mail requested documentation to:

> PERM Review Contractor
> Attn: Medical Records Manager
> CNI Advantage, LLC
> 1300 Piccard Drive, Suite 204
> Rockville, MD 20850

4. Email

Option One: Send Encrypted secure email to Records@permrc.com

Option Two: Send Encrypted file to Records@permrc.com and contact PERM Customer Service Representatives at 301-987-1100 to provide the file encryption password.

If your facility has more than one PERM request, please email each record separately.
Please include the PERM ID in the subject line.

NOTE: We are not authorized to reimburse providers/suppliers for the cost of copying or mailing records, so we cannot accept invoices for copying service fees.