

PERM Review Contractor  
RY 2019 Cycle 1 Claim Category Matrix

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
1	<b>Inpatient Hospital Services:</b> <ul style="list-style-type: none"> <li>Acute Inpatient</li> <li>Long-Term Acute</li> <li>Acute Inpatient Rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li><b>Admission History and Physical (H&amp;P)</b></li> <li><b>Physician Orders and Progress Notes (<i>signed and dated</i>)</b></li> <li><b>Medication Administration Record (MAR)</b></li> <li><b>Discharge Summary</b></li> <li>Admission Face Sheet/Coding Summary</li> <li>Emergency Department Record and Admission Order/Notes</li> <li>Nursing Assessment/Notes</li> <li>Consultation Reports/Notes</li> <li>Cardiovascular and Respiratory Reports</li> <li>Itemized Billing Sheet (<i>if required based on payment method</i>)</li> <li><b>Note:</b> 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.</li> </ul>	
		<ul style="list-style-type: none"> <li>Ambulance Services</li> <li>Dialysis Treatment Record/Notes</li> <li>Operative and Procedure Reports/Notes</li> <li>Anesthesia (<i>Pre- and Post-Op</i>) and Peri-operative Record/Notes (<i>with start and stop times</i>)</li> <li>Laboratory and Diagnostic Tests/Reports</li> <li>Labor and Delivery Record/Notes</li> <li>All Transfer Forms</li> <li>Physical Therapy: Evaluation/Re-evaluation/Notes</li> <li>Speech Language Pathology: Evaluation/Re-evaluation/Notes</li> <li>Occupational Therapy: Evaluation/Re-evaluation/Notes</li> </ul>	
2	<b>Psychiatric, Mental, and Behavioral Health:</b> <ul style="list-style-type: none"> <li>In/Outpatient Psychological, Psychiatric, and Behavioral Health Services</li> <li>Drug and Alcohol In/Outpatient Svcs</li> <li>Group Homes</li> </ul>	<ul style="list-style-type: none"> <li><b>Clinic/Office Visit Record/Notes</b></li> <li><b>Treatment Plan and Goals (<i>ISP, IPP, IFSP, POC in effect during sampled date/s of service</i>)</b></li> <li><b>Psychiatric Certification for Admission</b></li> <li><b>Admission History and Physical (H&amp;P)</b></li> <li><b>Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</b></li> <li><b>Mental Health Progress/Therapy Notes/Daily Attendance Logs (<i>with start and stop times</i>)</b></li> <li><b>Medication Administration Record (MAR)</b></li> <li><b>Note:</b> 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.</li> </ul>	
		<ul style="list-style-type: none"> <li>Psychiatric Evaluation/Testing</li> <li>Consultation Reports/Notes</li> <li>Nursing Assessment, Flowsheets/Notes</li> <li>Treatment Administration Record/Notes</li> <li>Discharge Summary</li> <li>All Transfer Forms: <i>Voluntary, Involuntary, or Court Ordered</i></li> <li>Documentation of Daily Patient Presence (<i>e.g., daily census, attendance log, etc.</i>)</li> <li>Emergency Department Record/Notes</li> <li>Evaluation and Management (<i>E&amp;M</i>)/Counseling Notes</li> <li>Admission Face Sheet/Coding Summary</li> </ul>	
3	<b>Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):</b> <ul style="list-style-type: none"> <li>Nursing Home and Convalescent Centers</li> <li>Chronic Care</li> </ul>	<ul style="list-style-type: none"> <li><b>Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</b></li> <li><b>Progress Notes for All Disciplines/Department (<i>to include physician's 60-day progress notes in effect during sampled date/s of service</i>)</b></li> <li><b>Documentation of Daily Patient Presence (<i>e.g., daily census, attendance log, etc.</i>)</b></li> <li><b>Medication Administration Record (MAR)</b></li> </ul>	
		<ul style="list-style-type: none"> <li>Physician Certification/Recertification (<i>signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame</i>)</li> <li>Treatment Administration Record/Notes</li> <li>All Transfer Forms</li> <li>Leave-of-Absence Documentation</li> <li>Nursing Assessment, Notes, and Flowsheets</li> <li>Treatment Plan (<i>in effect during sampled date/s of service</i>)</li> <li>Admission Face Sheet</li> </ul>	

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4	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	<ul style="list-style-type: none"> <li><b>Annual Physical Exam (if required)</b></li> <li><b>Treatment Plan (in effect during sampled date/s of service)</b></li> <li><b>Documentation of Daily Patient Presence (e.g., daily census, attendance log, etc.)</b></li> <li><b>Physician Orders (signed and dated; include all orders relevant to sampled claim)</b></li> <li>Leave-of-Absence Documentation</li> <li><b>Note:</b> 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.</li> </ul>	<ul style="list-style-type: none"> <li>Progress Notes for All Disciplines</li> <li>Medication Administration Record (MAR)</li> <li>Treatment Administration Record/Notes</li> <li>All Transfer Forms</li> <li>Nursing Assessment, Notes, and Flowsheets</li> <li>Physician Certification/Recertification (signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)</li> <li>Admission Face Sheet</li> </ul>
5	<b>Clinic Services:</b> <ul style="list-style-type: none"> <li>Hospital-based clinics</li> <li>Federally Qualified Health Centers (FQHC)</li> <li>Indian Health Svcs</li> <li>Outpatient Rural Health Clinic (RHC)</li> </ul>	<ul style="list-style-type: none"> <li><b>Encounter/Clinic Visit Record/Notes (signed and dated)</b></li> <li>Clinic Face Sheet</li> <li>Evaluation and Management (E&amp;M)/Counseling Notes</li> <li>Treatment Plan (in effect during sampled date/s of service)</li> <li>Nursing Notes</li> <li>Dialysis Treatment Record/Notes</li> <li><b>Note:</b> The document that is bolded is frequently required document for this category and service type. Please include in document submission if applicable to sampled claim.</li> </ul>	<ul style="list-style-type: none"> <li>Related Laboratory/Diagnostic Reports</li> <li>Physician Orders (signed and dated; include all orders relevant to sampled claim)</li> <li>Pharmacy Services and Medication Administration Record (MAR)</li> <li>Dental and Diagnostic Service Records</li> <li>Immunization Record</li> </ul>
6	Physicians and other Licensed Practitioners Services (Includes APN, PA, Nurse Midwife, and Midwife)	<ul style="list-style-type: none"> <li><b>Encounter/Office Visit/Clinic Record/Notes (signed and dated)</b></li> <li>Prenatal/Antepartum/Postpartum Record/Notes (signed and dated)</li> <li>Evaluation and Management (E&amp;M)/Counseling Notes (signed and dated)</li> <li>Related Laboratory/Diagnostic Reports</li> <li>Treatment Plan (in effect during sampled date/s of service)</li> <li>Procedure Record/Notes</li> </ul>	<ul style="list-style-type: none"> <li>Immunization Record</li> <li>Medication Administration Record (MAR)</li> <li>Dialysis Treatment Record/Notes</li> <li>Patient Education Documentation</li> <li>Prior Authorization (if required)</li> <li>Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)</li> </ul>

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		<ul style="list-style-type: none"> <li><b>Note:</b> The document that is bolded is frequently required document for this category and service type. Please include in document submission if applicable to sampled claim.</li> </ul>	
7	Dental and Oral Surgery Services	<ul style="list-style-type: none"> <li><b>Dental or Orthodontic Clinical Notes (signed and dated)</b></li> <li>Dental or Orthodontic Assessment</li> <li>Dental Chart (related to sampled date/s of service)</li> <li>Dental or Orthodontic Plan of Care (in effect during sampled date/s of service)</li> <li><b>Note:</b> The document that is bolded is frequently required document for this category and service type. Please include in document submission if applicable to sampled claim.</li> </ul>	<ul style="list-style-type: none"> <li>Dental History</li> <li>Dental X-Ray Notes (please <b>do not</b> send x-rays)</li> <li>Procedure Record/Notes (signed and dated)</li> <li>Prior Authorization (if required)</li> <li><b>Note:</b> Clinical Documentation (notes, plan of care, etc.) issued from electronic records must be signed and dated (electronic signature acceptable if permitted by state regulations).</li> </ul>
8	Prescribed Drugs	<ul style="list-style-type: none"> <li><b>Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form: Front and Back (if applicable)—with Patient Name, Date of Birth, Address, Telephone Number, Physician Name, and Signature (signature method as required/permitted by state regulations)</b></li> <li><b>Documented Proof of Acceptance or Refusal of Counseling</b></li> <li><b>Member Pharmacy Signature Log/Proof of Delivery</b></li> <li><b>Member Profile with Refill History for the Sampled Medication</b></li> <li><b>Proof of Delivery to SNF, NF, ICF, ICF/IID, or Personal Residence</b></li> </ul>	<ul style="list-style-type: none"> <li>Prior Authorization (if required)</li> <li>Signed Physician Medication Order for Skilled Nursing Facility (SNF)/Nursing Facility (NF) or Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (ICF/IID)</li> <li>Name of Drug, Dose, Route, Number Dispensed, and Number of Refills</li> <li>NDC Number</li> <li><b>Note:</b> 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.</li> </ul>
9	Home Health Services: <ul style="list-style-type: none"> <li>Home Health Agency Services</li> <li>Medical Supplies, Equipment, and Appliances through the Agency</li> </ul>	<ul style="list-style-type: none"> <li><b>Physician Certification/Recertification (Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)</b></li> <li><b>Plan of Care (in effect during sampled date/s of service)</b></li> <li><b>Physician Orders (signed and dated; include all physician orders relevant to sampled claim)</b></li> <li>Initial/Intake Assessment</li> <li>Nursing Assessments and Notes</li> <li>Nursing Care Plan/Treatment Care Plan (in effect during sampled date/s of service)</li> </ul>	<ul style="list-style-type: none"> <li>Speech Therapy (ST) Assessments and Progress Toward Goals (time in and out)</li> <li>Speech Language Pathology (SLP) Assessments and Progress Toward Goals (time in and out)</li> <li>Occupational Therapy (OT) Assessments and Progress Toward Goals (time in and out)</li> <li>Medical Supplies, Equipment, and Appliances Order/Prescription (signed and dated)</li> <li>Medical Supplies, Equipment, and Appliances Signature Log/Proof of Delivery</li> </ul>

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		<ul style="list-style-type: none"> <li>Home Health Aide Notes/Worksheets (<i>time in and out</i>)</li> <li>Physical Therapy (PT) Assessments and Progress Toward Goals (<i>time in and out</i>)</li> <li>Face-to-Face Encounter Record/Notes (<i>if required</i>)</li> <li><b>Note:</b> 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.</li> <li>Total Time Spent for Units Billed (<i>and unit identification, i.e., 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> <li>Infusion Therapy, Medication/Fluid Name and Administration Specifics (<i>time in and out</i>)</li> </ul>
10	<b>Personal Support Services:</b> <ul style="list-style-type: none"> <li>Personal Care Svcs <ul style="list-style-type: none"> <li>Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care</li> </ul> </li> <li>Case Management/Targeted Case Management Svcs</li> <li>Private Duty Nursing</li> <li>Meal Delivery Svcs</li> </ul>	<b>Personal Care Services (Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care):</b> <ul style="list-style-type: none"> <li><b>Timesheet, Completed and Signed (include description of services approved and provided)</b></li> <li><b>Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)</b></li> <li><b>Service/Treatment Plan and Goals (in effect during sampled date/s of service)</b></li> <li><b>Prior Authorization (if required)</b></li> <li>Beneficiary's Signature/Proof-of-Service Receipt</li> <li>Physician Certification/Recertification (<i>Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame</i>)</li> <li>Statement of Medical Necessity</li> <li>Physician Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</li> <li>Initial Intake Assessment/Reassessment (<i>as relevant to dates of service</i>)</li> </ul> <b>Case Management/Targeted Case Management Services:</b> <ul style="list-style-type: none"> <li><b>Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)</b></li> <li><b>Prior Authorization (if required)</b></li> <li>Case Management Invoice/Billing/Timesheet</li> <li>Beneficiary's Signature/Proof-of-Service Receipt</li> <li>Referral for Case Management/Statement of Necessity</li> <li>Prior Authorization (<i>if required</i>)</li> <li>Case Management Care Plan/Updates and Notes (<i>in effect during sampled date/s of service; including telephonic contact</i>)</li> </ul> <b>Private Duty Nursing:</b> <ul style="list-style-type: none"> <li><b>Prior Authorization (if required)</b></li> <li><b>Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)</b></li> <li>Physician Orders/Statement of Medical Necessity (<i>signed and dated; include all physician orders relevant to sampled claim</i>)</li> <li>Initial/Intake Assessment/Reassessment</li> <li>Nursing Flowsheets/Notes (<i>completed and signed with time in and out</i>)</li> <li>Beneficiary's Signature/Proof-of-Service Receipt</li> </ul> <b>Meal Delivery Services:</b> <ul style="list-style-type: none"> <li><b>Meal Delivery Records/Signature Logs/Proof of Delivery</b></li> <li>Referral for Services</li> <li>Prior Authorization (<i>if required</i>)</li> </ul>

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		<ul style="list-style-type: none"> <li><b>Note:</b> <i>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.</i></li> </ul>
11	<b>Hospice Services:</b> <ul style="list-style-type: none"> <li>Services provided at Home, Nursing Facility, Hospital, or Hospice Facility</li> </ul>	<ul style="list-style-type: none"> <li><b>Hospice Nurse Visit and Progress Notes</b></li> <li><b>Physician Certification/Recertification (<i>Physician Certification signed and dated; in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame</i>)</b></li> <li><b>Physician's Orders (<i>signed and dated; include all orders relevant to sampled claim</i>)</b></li> <li><b>Hospice Benefit Election/Revocation Forms</b></li> <li><b>Note:</b> <i>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.</i></li> <li>Initial/Intake Assessment</li> <li>Multidisciplinary Care Plan and Notes (<i>in effect during sampled date/s of service</i>)</li> <li>Social Work Notes</li> <li>Home Health Aide Notes/Worksheets</li> <li>Medication Administration Record (MAR)</li> <li>Documentation of Daily Patient Presence (<i>e.g., daily census, attendance log, etc.</i>)</li> <li>Admission Face Sheet</li> </ul>
12	<b>Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, and Rehabilitation Services, Ophthalmology, Optometry, and Optical Services Necessary Supplies and Equipment</b>	<ul style="list-style-type: none"> <li><b>Orders (<i>signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim</i>)</b></li> <li><b>Treatment Plan and Goals (<i>in effect during sampled date/s of service</i>)</b></li> <li><b>Physical Therapy: Evaluation/Re-evaluation/Notes (<i>signed and dated with start and stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.</i>)</b></li> <li><b>Occupational Therapy: Evaluation/Re-evaluation/Notes (<i>signed and dated with start and stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.</i>)</b></li> <li><b>Speech Language Pathology: Evaluation/Re-evaluation/Notes (<i>signed and dated with start/stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.</i>)</b></li> <li><b>Audiology: Evaluation/Re-evaluation/Notes (<i>signed and dated with start and stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.</i>)</b></li> <li><b>Respiratory Therapy: Evaluation and Re-evaluation/Notes (<i>signed and dated with start and stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.</i>)</b></li> <li><b>Durable Medical Equipment Receipt Signature Log/Proof of Delivery</b></li> <li><b>Proof of Delivery/Signature Logs</b></li> <li>Diagnostic Test Results</li> <li>Ophthalmology Visit and Progress Notes (<i>signed and dated</i>)</li> <li>Optometry and Optical Visit Notes (<i>signed and dated</i>)</li> <li>Eyeglass/Optician Invoices</li> <li>Prior Authorization for Durable Medical Equipment Needed for Provision of Therapy Services (<i>if required</i>)</li> <li><b>Note:</b> <i>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.</i></li> </ul>

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13	Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-based Services	<b>Home and Community-based Services (HCBS), Adult Day Care, Foster Care, or Waiver Services:</b> <ul style="list-style-type: none"> <li>Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (<i>signed and dated, with amount, type, start/stop times, and duration</i>)</li> <li>Service/Treatment Plan and Goals (<i>in effect during sampled date/s of service</i>)</li> <li>Individual Education Plan (<i>IEP</i>); Individual Program Plan (<i>IPP</i>); Individual Service Plan (<i>ISP</i>); Individual Family Service Plan (<i>IFSP</i>) (<i>in effect during sampled date/s of service</i>)</li> <li><b>Note:</b> 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.</li> </ul>	<ul style="list-style-type: none"> <li>Case Management/Supervisory Visit Notes</li> <li>DME Signature Log/Proof of Delivery</li> <li>Prior Authorization (<i>if required</i>)</li> <li>Orders from Identified Qualified Provider (<i>if required</i>)</li> </ul>
		<b>School-based Services:</b> <ul style="list-style-type: none"> <li>Individual Education Plan (<i>IEP</i>); Individual Program Plan (<i>IPP</i>); Individual Service Plan (<i>ISP</i>); Individual Family Service Plan(<i>IFSP</i>) (<i>in effect during sampled date/s of service, include Physician Orders if required</i>)</li> <li>Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (<i>signed and dated, with amount, type, start/stop times, and duration</i>)</li> <li>Orders from Identified Qualified Provider</li> <li>Psychological Testing, Mental Health Counseling Notes, Treatment Plan, and Progress Toward Goals</li> <li>Case Management, Skilled Nursing, Social Work, and/or Personal Care Service</li> <li><b>Note:</b> 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.</li> </ul>	<ul style="list-style-type: none"> <li>Assistive Mobility, Vision, and/or Hearing Technology Device</li> <li>Deaf Interpreter or Sign Language Service</li> <li>PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (<i>RT</i>): Evaluation and Re-evaluation/Notes</li> <li>Medication Administration Record (<i>MAR</i>)</li> <li>Service/Treatment Plan and Goals (<i>in effect during sampled date/s of service</i>)</li> </ul> <p>Transportation Provider:</p> <ul style="list-style-type: none"> <li>Account Ledger and Billing Statements</li> <li>Ground Mileage/Pick-up and Drop-off Details</li> </ul>
14	Laboratory, X-ray and Imaging Services	<ul style="list-style-type: none"> <li>Physician Order Sheet (<i>signed and dated</i>)</li> <li>Laboratory Report/Results</li> </ul>	<ul style="list-style-type: none"> <li>Radiology/Imaging Report/Results and Interpretation (<i>please do not send x-rays</i>)</li> <li><b>Note:</b> 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.</li> </ul>

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15	<b>Outpatient Hospital Services:</b> <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Emergency Svcs</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Operative and Procedure Reports/Notes</b></li> <li>• <b>Emergency Department Record/Notes</b></li> <li>• <b>Physician Orders and Progress Notes (<i>signed and dated</i>)</b></li> <li>• Admission Face Sheet/Coding Summary</li> <li>• Admission History and Physical (<i>H&amp;P</i>)</li> <li>• Nursing Assessment/Notes</li> <li>• Consultation Reports/Notes</li> <li>• Cardiovascular and Respiratory Reports</li> <li>• Physical and Occupational Therapy Assessments/Notes</li> <li>• Speech Language Pathology (<i>SLP</i>) Assessments/Notes</li> </ul> <p>• <b>Note:</b> <i>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.</i></p>	<ul style="list-style-type: none"> <li>• Ambulance Services</li> <li>• Medication Administration Record (<i>MAR</i>)</li> <li>• Dialysis Treatment Record/Notes</li> <li>• Anesthesia (<i>Pre- and Post-Op</i>) and Peri-operative Record/Notes (<i>with start and stop times</i>)</li> <li>• Laboratory and Diagnostic Tests/Reports</li> <li>• Labor and Delivery Record/Notes</li> <li>• Discharge Summary</li> <li>• All Transfer Forms</li> <li>• Itemized Billing Sheet (<i>if required based on payment method</i>)</li> </ul>
16	<b>Durable Medical Equipment (DME) and Supplies, Prosthetic /Orthopedic Devices, and Environmental Modifications</b>	<ul style="list-style-type: none"> <li>• <b>Physician Orders (<i>signed and dated; include all relevant orders for the sampled claim</i>)</b></li> <li>• <b>Durable Medical Equipment/Supplies Prescription (<i>signed and dated</i>)</b></li> <li>• <b>Proof of Delivery/Signature Logs (<i>dated</i>)</b></li> <li>• <b>Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, and/or Supplies (<i>if required</i>)</b></li> </ul> <p>• <b>Note:</b> <i>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.</i></p>	<ul style="list-style-type: none"> <li>• Prosthetic/Orthopedic Device Assessments/Notes (<i>dated</i>)</li> <li>• Invoice for Services (<i>dated</i>)</li> <li>• Total Time Spent for Units Billed (<i>i.e., 15 min., 30 min., 1 hr., 1 visit, etc.</i>)</li> </ul>
17	<b>Transportation and Accommodations</b>	<ul style="list-style-type: none"> <li>• <b>Emergency Medical Transportation Records with Documented Medical Necessity of Ambulance Transport (<i>if applicable</i>)</b></li> <li>• <b>Ground Mileage/Air Mileage Details</b></li> <li>• <b>Starting Point and Destination/Odometer Readings</b></li> <li>• <b>Transportation Log with Member Signature</b></li> </ul>	<ul style="list-style-type: none"> <li>• Transportation Schedule for Requested Dates of Service</li> <li>• Physician Order for Transportation/Accommodations (<i>if applicable</i>)</li> <li>• Documentation reflecting Medical Necessity for Transportation and Accommodations</li> <li>• Chaperone Documentation, if Appropriate (<i>approval/authorization</i>)</li> </ul>

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18	<b>Denied Claims</b>	No Documents/Medical Records Requested
19	<b>Crossover Claims</b>	No Documents/Medical Records Requested
30	<b>Capitated Care/Fixed Payments</b> <ul style="list-style-type: none"> <li>Fixed Payments for Primary Care Case Management (PCCM)</li> <li>Medicare Part A Premiums</li> <li>Medicare Part B Premiums</li> <li>Health Insurance Premium Payments (HIPP)</li> <li>Aggregate Payments</li> </ul>	No Documents/Medical Records Requested
50	<b>Managed Care</b> <ul style="list-style-type: none"> <li>Capitated Payments to HMO, HIO, or PACE Plan</li> <li>Capitated Payments to Prepaid Health Plans (PHPs)</li> </ul>	No Documents/Medical Records Requested
99	<b>Unknown</b>	Claim Data is Individually Reviewed for Category Determination