

**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: 5**

**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.

**Dental Services:**

Dental Chart

Dental Plan of Care

Dental x-rays

Dental visit clinical notes

Dental History

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 information 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

Dental5\_020808.pdf