Category	Type of Service	Documents Requested (If applicable to sampled claim)	
1	**Inpatient Hospital Services:** • Acute Inpatient • Long Term Acute • Acute Inpatient Rehabilitation	• Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Emergency Department Record & Admit / Notes • Admission History & Physical (H&P) • Physician Orders & Progress Notes (*signed*) • Nursing Assessment / Notes • Consultation Reports / Notes • Cardiovascular & Respiratory Reports • Physical & Occupational Therapy Assessments / Notes • Speech Language Pathology (SLP) Assessments / Notes • Ambulance Services	• Medication Administration Record (MAR) • Vital Sign & Intake & Output (I&O) Flowsheets • Dialysis Record / Notes • Operative & Procedure Reports / Notes • Anesthesia (Pre and Post-Op) & Peri-operative Record / Notes (with start and stop times) • Laboratory & Diagnostic Tests / Reports • Labor and Delivery Record / Notes • Discharge Summary • All Transfer Forms • Itemized billing sheet (*If required based on payment method*)
2	**Psychiatric, Mental, & Behavioral Health** • In/Outpatient Psychological, Psychiatric, and Behavioral Health Services • Drug and Alcohol In/Outpatient Svcs • Group Homes	• Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Psychiatric Certification for Admission • Emergency Department Record / Notes • Clinic / Office Visit Record / Notes • Evaluation & Management (E&M) / Counseling Notes • Admission History and Physical (H&P) • Physician Orders (*signed/ dated)* • Mental Health Progress / Therapy Notes / Daily Attendance Logs (*Start/Stop Times)*	• Psychiatric Evaluation / Testing • Treatment Plan & Goals • Consultation Reports / Notes • Nursing Assessment, Flowsheets/Notes • Medication Administration Record (MAR) • Treatment Administration Record / Notes • Discharge Summary • All Transfer Forms: *Voluntary, Involuntary, or Court Ordered*
3	**Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):** • Nursing Home and Convalescent Centers • Chronic Care	• Admission Face Sheet • 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)* • Physician Orders *(signed and dated; include all orders relevant to sampled claim)* • Progress Notes for All Disciplines / Department	• Medication Administration Record (MAR) • Treatment Administration Record / Notes • Documentation of Daily Patient Presence • All Transfer Forms • Leave of Absence Documentation

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
4	**ICF for Persons with Mental Retardation (ICF/MR) and ICF/Group Homes**	• Admission Face Sheet • Physician Certification/Recertification (*signed &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*) • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Progress Notes for All Disciplines / Departments	• Medication Administration Record (MAR) • Treatment Administration Record / Notes • Documentation of Daily Patient Presence • All Transfer Forms • Leave of Absence Documentation • Nursing Assessment, Notes, & Flowsheets
5	**Clinic Services:** • Federally Qualified Health Centers (FQHC) • Indian Health Svcs • Outpatient Rural Health Clinic (RHC)	• Clinic Face Sheet • Encounter / Clinic Visit Record / Notes *(signed & dated)* • Evaluation and Management (E&M) / Counseling Notes • Treatment Plan *(in effect during sampled date/s)* • Dialysis Treatment Record / Notes	• Related Laboratory / Diagnostic Reports • Physician Orders (*signed & dated*) • Pharmacy Services and Medication Administration Record (MAR) • Dental and Diagnostic Service Records
6	**Physicians, Physician Clinics, and other Licensed Practitioners' Services (*Includes Nurse Midwife & Midwife*):**	**Physician Clinic Services:** • Clinic Face Sheet • Encounter / Office Visit Record / Notes *(signed & dated)* • Evaluation and Management (E&M) /Counseling Notes *(signed* • *and dated)* • Related Laboratory / Diagnostic Reports • Treatment Plan *(in effect during sampled date/s)*	• Procedure Record / Notes • Immunization Record • Medication Administration Record (MAR) • Dialysis Treatment Records and Notes • Patient Education Documentation • Prior Authorization (if required) • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc)*
		Physicians & Other Licensed Practitioners' Services: • Encounter/ Office Visit / Clinic Record & Notes *(signed & dated)*	• Evaluation & Management(E&M) / Counseling Notes *(Signed & dated)* • Related Testing / Evaluations and Reports

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
7	**Dental and Oral Surgery Services:**	• Dental/Orthodontic Assessment • Dental Chart *(related to sampled dates of service)* • Dental/Orthodontic Clinical Notes (*signed & dated*) • Dental/Orthodontic Plan of Care *(in effect during sampled date/s of service)* *Note: Clinical Documentation (notes, plan of care, etc.) issued from electronic records must be signed & dated (electronic signature acceptable if permitted by state regulations).*	• Dental History • Dental X-Ray Notes (*please **do not** send x-rays*) • Procedure Record / Notes *(signed & dated)* • Prior Authorization *(if required)*
8	**Prescribed Drugs:**	• 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, & signature *(signature method as required/permitted by state regulations)* • Name of Drug, Dose, Route, Number Dispensed, & Number of Refills • NDC Number	• Prior Authorization (*if required*) • Member Pharmacy Signature Log / Proof of Delivery • Proof of acceptance or refusal of counseling • Signed Physician Medication Order for Skilled Nursing Facility (SNF) / Nursing Facility (NF) or Intermediate Care Facility (ICF) for Persons with Mental Retardation (ICF/MR) • Proof of Delivery to SNF, NF, ICF, or ICF/MR • Member Profile with Refill History
9	**Home Health Services:** • Home Health Agency Services & Medical Supplies • Equipment and Appliances through the Agency	• Physician Certification/Recertification/Form 485 Plan of Care • Physician Orders (*signed & dated; include all physician orders relevant to sampled claim*) • Initial / Intake Assessment • Nursing Assessments and Notes • Nursing Care Plan • Home Health Aide Notes / Worksheets (*time in & out*) • Physical Therapy (PT) Assessments & progress toward goals (*time in & out*) • DME Order/Prescription (*signed & dated*)	• Occupational Therapy (OT) Assessments & progress toward goals (*time in & out*) • Speech Language Pathology (SLP) Assessments & progress toward goals (*time in & out*) • Total Time Spent for Units Billed *(& unit identification i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)* • Infusion Therapy, medication/fluid name & administration specifics (*time in & out*) • DME Signature Log / Proof of Delivery

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
10	**Personal Support Services:** • Personal Care Svcs Personal Care • Personal Care Attendant, Aide, Homemaker Services, and Respite Care • Targeted Case Management Svcs • Private Duty Nursing • Meal Delivery Svcs	**Personal Care Services *(Qualified Service Provider, Personal Care Attendant, Aide, Homemaker services and Respite Care)*:** • Physician Certification / Recertification /Statement of Medical Necessity • Physician Orders (*signed & dated; **include all orders relevant to sampled claim***) • Plan of Care / Service / Treatment Plan (include approved ADL/IADL services description)	• Initial Intake Assessment / Reassessment (as relevant to dates of service) • Timesheet, completed & signed (include description of services approved & provided) • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*
		Case Management/Targeted Case Management Services: • Referral for Case Management / Statement of Necessity • Case Management Care Plan / Updates & Notes (*including telephonic contact*) • Goals / Timelines / Outcome Measures (with description of services approved & provided)	• Case Management Invoice / Billing • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*
		Private Duty Nursing: • Physician Orders / Statement of Medical Necessity (*signed & dated; **include all physician orders relevant to sampled claim***) • Initial / Intake Assessment / Reassessment	• Nursing Flowsheets/Notes (completed & signed with *time in & out*) • Recipient's signature / proof of service receipt • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc.)*
		Meal Delivery Services: • Referral for Services • Meal Delivery Records / Signature Logs / Proof of Delivery	
11	**Hospice Services:** • Services provided at Home, Nursing Facility, Hospital, or Hospice Facility	• Admission Face Sheet • Physician Certification / Recertification (*signed and dated; include cert/re-cert done prior to date(s) of service if not completed during requested time frame*) • Hospice Benefit Election / Revocation Forms • Initial / Intake Assessment • Hospice Nurse Visit and Progress Notes • Multidisciplinary Care Plan and Notes	• Social Work Notes • Home Health Aide Notes / Worksheets • Medication Administration Record (MAR) • Facility Verification of Daily Presence

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
12	**Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, & Rehabilitation Services, Necessary Supplies & Equipment, Ophthalmology, Optometry, and Optical Services**	• Orders (*signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim*) • Physical Therapy: Evaluation / Re-evaluation / Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Occupational Therapy: Evaluation/ Re-evaluation/Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed & dated with start /stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Ophthalmology Visit and Progress Notes *(signed and dated)* • Optometry and Optical Visit Notes *(signed and dated)*	• Audiology: Evaluation / Re-evaluation / Notes *(signed & dated with min, 1hr, 1 visit, etc.)* • Respiratory Therapy: Evaluation and Re-evaluation / Notes *(signed & dated with start & stop times, & total time spent for units billed i.e. 15 min, 30 min, 1hr, 1 visit, etc.)* • Prior Authorization for Durable Medical Equipment needed for provision of therapy services (*if required*) Durable Medical Equipment Receipt Signature Log / Proof of Delivery • Diagnostic Test Results • Eyeglass / Optician Invoices Proof of Delivery / Signature Logs
13	**Day Habilitation and Waiver Programs, Adult Day Care, Foster Care, and School Based Services**	**Home and Community Based Services (HCBS) Waivers** *(signed & dated, with amount, type, start/stop times, & duration)*: • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records Service/Treatment Plan & Goals (*in effect during sampled dates of service):* • Individual Education Plan (IEP); Individual Program Plan (IPP); Individual Service Plan (ISP); Individual Family Service Plan (IFSP)	Case Management / Supervisory Visit Notes DME Signature Log / Proof of Delivery Transportation Provider: • Account Ledger and Billing Statements • Ground Mileage / Pick-up & Drop Off Details
		School Based Services *(signed & dated with amount, type, start/stop times, & duration)*: • Orders from identified qualified provider • Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, & Records • Psychological Testing, Mental Health counseling notes, treatment plan, & progress toward goals • Case Management, Skilled Nursing, Social Work, &/or Personal Care Service Service/Treatment Plan & Goals (*in effect during sampled dates of service):* • Individual Education Plan (IEP); Individual Program Plan (IPP); Individual Service Plan (ISP); Individual Family Service Plan (IFSP)	• Assistive Mobility, Vision, &/or Hearing Technology Device • Deaf Interpreter or Sign Language Service • PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (RT): Evaluation and Re-evaluation/Notes • Medication Administration Record (MAR) Transportation Provider: • Account Ledger and Billing Statements Ground Mileage / Pick-up & Drop Off Details

Category	Type of Service	Documents Requested (If applicable to sampled claim)	
14	**Laboratory, X-ray and Imaging Services:**	• Physician Order Sheet *(signed & dated)* • Laboratory Report / Results	Radiology / Imaging Report / Results & Interpretation (*please **do not** send x-rays)*
15	**Outpatient Hospital Services** • Outpatient Emergency Svcs	• Admission Face Sheet / Coding Summary • Physician Coding Query Forms • Emergency Department Record / Notes • Admission History & Physical (H&P) • Physician Orders & Progress Notes (*signed*) • Nursing Assessment / Notes • Consultation Reports / Notes • Cardiovascular & Respiratory Reports • Physical & Occupational Therapy Assessments / Notes • Speech Language Pathology (SLP) Assessments / Notes Ambulance Services	• Medication Administration Record (MAR) • Vital Sign & Intake & Output (I&O) Flowsheets • Dialysis Record / Notes • Operative & Procedure Reports / Notes • Anesthesia (Pre and Post-Op) & Peri-operative Record / Notes (with start and stop times) • Laboratory & Diagnostic Tests / Reports • Labor and Delivery Record / Notes • Discharge Summary • All Transfer Forms • Itemized billing sheet (*If required based on payment method*)
16	**Durable Medical Equipment (DME) & Supplies, Prosthetic / Orthopedic Devices, & Environmental Modifications**	• Physician Orders (*signed and dated*) • Durable Medical Equipment / Supplies Prescription (*signed and dated*) • Prosthetic / Orthopedic Device Assessments / Notes (*dated*) • Proof of Delivery / Signature Logs *(dated)*	• Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, &/or Supplies *(if required)* • Invoice for Services *(dated)* • Total Time Spent for Units Billed *(i.e. 15 min., 30 min., 1 hr., 1 visit, etc)*
17	**Transportation and Accommodations:**	• Emergency Medical Transportation Records with documented medical necessity of Ambulance transport *(if applicable)* • Transportation Schedule for Requested dates of service • Starting Point and Destination / Odometer Readings • Transportation Log with Member Signature • Ground Mileage / Air Mileage Details	• Physician Order for Transportation / Accommodations (*if applicable)* • Documentation reflecting Medical Necessity for Transportation • Documentation reflecting necessity for Accommodations *(if applicable)* • Transportation Provider's Account Ledger / Billing Statements

Category	Type of Service	Documents Requested (If applicable to sampled claim)
18	**Denied Claims**	No Documents / Medical Records Requested
19	**Crossover Claims**	No Documents / Medical Records Requested
30	**Capitated Care/Fixed Payments** • Capitated Payments to Primary Care Case Management • Medicare Part A Premiums • Medicare Part B Premiums • Health Insurance Premium Payments (HIPP)	No Documents / Medical Records Requested
50	**Managed Care** • Capitated Payments to HMO, HIO, or PACE Plan • Capitated Payments to Prepaid Health Plans (PHPs)	No Documents / Medical Records Requested
99	**UNKNOWN**	Claim Data is Individually Reviewed for Category Determination