Category	Type of Service	Documents Requested (if applicable to sampled claim)	
1	**Inpatient Hospital Services:** • Acute Inpatient • Long-Term Acute • Acute Inpatient Rehabilitation	• **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*) • ***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.*	• 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
2	**Psychiatric, Mental, and Behavioral Health:** • In/Outpatient Psychological, Psychiatric, and Behavioral Health Services • Drug and Alcohol In/Outpatient Svcs • Group Homes	• **Clinic/Office Visit Record/Notes** • **Treatment Plan and Goals *(ISP, IPP, IFSP, POC in effect during sampled date/s of service)*** • **Psychiatric Certification for Admission** • **Admission History and Physical *(H&P)*** • **Physician Orders (*signed and dated; include all orders relevant to sampled claim)*** • **Mental Health Progress/Therapy Notes/Daily Attendance Logs *(with start and stop times)*** • **Medication Administration Record *(MAR)*** • ***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.*	• Psychiatric Evaluation/Testing • Consultation Reports/Notes • Nursing Assessment, Flowsheets/Notes • Treatment Administration Record/Notes • Discharge Summary • All Transfer Forms: *Voluntary, Involuntary, or Court Ordered* • Documentation of Daily Patient Presence *(e.g., daily census, attendance log, etc.)* • Emergency Department Record/Notes • Evaluation and Management *(E&M)*/Counseling Notes • Admission Face Sheet/Coding Summary
3	**Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF):** • Nursing Home and Convalescent Centers • Chronic Care	• **Physician Orders *(signed and dated; include all orders relevant to sampled claim)*** • **Progress Notes for All Disciplines/Department *(to include physician's 60-day progress notes in effect during sampled date/s of service)*** • **Documentation of Daily Patient Presence (*e.g., daily census, attendance log, etc.)*** • **Medication Administration Record *(MAR)***	• 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)* • Treatment Administration Record/Notes • All Transfer Forms • Leave-of-Absence Documentation • Nursing Assessment, Notes, and Flowsheets • Treatment Plan *(in effect during sampled date/s of service)* • Admission Face Sheet

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
		• ***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.*	
4	**Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes**	• **Annual Physical Exam *(if required)*** • **Treatment Plan *(in effect during sampled date/s of service)*** • **Documentation of Daily Patient Presence *(e.g., daily census, attendance log, etc.*** • **Physician Orders (*signed and dated; include all orders relevant to sampled claim*)** • Leave-of-Absence Documentation • **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.*	• Progress Notes for All Disciplines • Medication Administration Record *(MAR)* • Treatment Administration Record/Notes • All Transfer Forms • Nursing Assessment, Notes, and Flowsheets • 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*) • Admission Face Sheet
5	**Clinic Services:** • Hospital-based clinics • Federally Qualified Health Centers (FQHC) • Indian Health Svcs • Outpatient Rural Health Clinic (RHC)	• **Encounter/Clinic Visit Record/Notes *(signed and dated)*** • Clinic Face Sheet • Evaluation and Management *(E&M)*/Counseling Notes • Treatment Plan *(in effect during sampled date/s of service)* • Nursing Notes • Dialysis Treatment Record/Notes • **Note:** *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.*	• Related Laboratory/Diagnostic Reports • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Pharmacy Services and Medication Administration Record *(MAR)* • Dental and Diagnostic Service Records • Immunization Record
6	**Physicians and other Licensed Practitioners Services (*Includes APN, PA, Nurse Midwife, and Midwife*)**	• **Encounter/Office Visit/Clinic Record/Notes *(signed and dated)*** • Prenatal/Antepartum/Postpartum Record/Notes *(signed and dated)* • Evaluation and Management *(E&M)*/Counseling Notes *(signed and dated)* • Related Laboratory/Diagnostic Reports • Treatment Plan *(in effect during sampled date/s of service)* • Procedure Record/Notes	• Immunization Record • Medication Administration Record *(MAR)* • Dialysis Treatment Record/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.)*

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
		• **Note:** *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.*	
7	**Dental and Oral Surgery Services**	• **Dental or Orthodontic Clinical Notes (*signed and dated*)** • Dental or Orthodontic Assessment • Dental Chart *(related to sampled date/s of service)* • Dental or Orthodontic Plan of Care *(in effect during sampled date/s of service)* • ***Note:*** *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.*	• Dental History • Dental X-Ray Notes (*please **do not** send x-rays*) • Procedure Record/Notes *(signed and dated)* • Prior Authorization *(if required)* ***Note**: Clinical Documentation (notes, plan of care, etc.) issued from electronic records must be signed and dated (electronic signature acceptable if permitted by state regulations).*
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, and Signature *(signature method as required/permitted by state regulations)*** • **Documented Proof of Acceptance or Refusal of Counseling** • **Member Pharmacy Signature Log/Proof of Delivery** • **Member Profile with Refill History for the <u>Sampled Medication</u>** • **Proof of Delivery to SNF, NF, ICF, ICF/IID, or Personal Residence**	• Prior Authorization (*if required*) • Signed Physician Medication Order for Skilled Nursing Facility *(SNF)*/Nursing Facility *(NF)* or Intermediate Care Facility *(ICF)* for Individuals with Intellectual Disabilities *(ICF/IID)* • Name of Drug, Dose, Route, Number Dispensed, and Number of Refills • NDC Number • **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.*
9	**Home Health Services:** • Home Health Agency Services • Medical Supplies, Equipment, and Appliances through the Agency	• **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)*** • **Plan of Care *(in effect during sampled date/s of service)*** • **Physician Orders (*signed and dated; include all physician orders relevant to sampled claim*)** • Initial/Intake Assessment • Nursing Assessments and Notes • Nursing Care Plan/Treatment Care Plan *(in effect during sampled date/s of service)*	• Speech Therapy *(ST)* Assessments and Progress Toward Goals *(time in and out)* • Speech Language Pathology *(SLP)* Assessments and Progress Toward Goals *(time in and out)* • Occupational Therapy *(OT)* Assessments and Progress Toward Goals *(time in and out)* • Medical Supplies, Equipment, and Appliances Order/Prescription *(signed and dated)* • Medical Supplies, Equipment, and Appliances Signature Log/Proof of Delivery

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
		• Home Health Aide Notes/Worksheets *(time in and out)* • Physical Therapy *(PT)* Assessments and Progress Toward Goals *(time in and out)* • Face-to-Face Encounter Record/Notes *(if required)* • **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.*	• Total Time Spent for Units Billed *(and unit identification, i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)* • Infusion Therapy, Medication/Fluid Name and Administration Specifics *(time in and out)*
10	**Personal Support Services:** • Personal Care Svcs • Qualified Service Provider, Personal Care Attendant, Aide, Homemaker Services, and Respite Care • Case Management/ 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)*:** • **Timesheet, Completed and Signed *(include description of services approved and provided)*** • **Total Time Spent for Units Billed *(i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)*** • **Service/Treatment Plan and Goals *(in effect during sampled date/s of service)*** • **Prior Authorization *(if required)*** • Beneficiary's Signature/Proof-of-Service Receipt	• 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)* • Statement of Medical Necessity • Physician Orders (*signed and dated; include all orders relevant to sampled claim*) • Initial Intake Assessment/Reassessment *(as relevant to dates of service)*
		Case Management/Targeted Case Management Services: • **Total Time Spent for Units Billed *(i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)*** • **Prior Authorization *(if required)*** • Case Management Invoice/Billing/Timesheet • Beneficiary's Signature/Proof-of-Service Receipt • Referral for Case Management/Statement of Necessity	• Prior Authorization *(if required)* • Case Management Care Plan/Updates and Notes *(in effect during sampled date/s of service; including telephonic contact*)
		Private Duty Nursing: • **Prior Authorization *(if required)*** • **Total Time Spent for Units Billed *(i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)*** • Physician Orders/Statement of Medical Necessity (*signed and dated; include all physician orders relevant to sampled claim*)	• Initial/Intake Assessment/Reassessment • Nursing Flowsheets/Notes *(completed and signed with time in and out)* • Beneficiary's Signature/Proof-of-Service Receipt
		Meal Delivery Services: • **Meal Delivery Records/Signature Logs/Proof of Delivery** • Referral for Services	• Prior Authorization *(if required)*

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
		• **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.*	
11	**Hospice Services:** • Services provided at Home, Nursing Facility, Hospital, or Hospice Facility	• **Hospice Nurse Visit and Progress Notes** • **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)*** • **Physician's Orders *(signed and dated; include all orders relevant to sampled claim)*** • **Hospice Benefit Election/Revocation Forms** • **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.*	• Initial/Intake Assessment • Multidisciplinary Care Plan and Notes *(in effect during sampled date/s of service)* • Social Work Notes • Home Health Aide Notes/Worksheets • Medication Administration Record *(MAR)* • Documentation of Daily Patient Presence *(e.g., daily census, attendance log, etc.)* • Admission Face Sheet
12	**Physical, Occupational, Respiratory Therapies, Speech Language Pathology, Audiology, and Rehabilitation Services, Ophthalmology, Optometry, and Optical Services Necessary Supplies and Equipment**	• **Orders (*signed and dated; include all physician or authorized relevant practitioner's orders related to sampled claim*)** • **Treatment Plan and Goals *(in effect during sampled date/s of service)*** • **Physical Therapy: Evaluation/Re-evaluation/Notes *(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.)*** • **Occupational Therapy: Evaluation/Re-evaluation/Notes *(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.)*** • **Speech Language Pathology: Evaluation/Re-evaluation/Notes *(signed and dated with start/stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.)*** • **Audiology: Evaluation/Re-evaluation/Notes *(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.)***	• **Respiratory Therapy: Evaluation and Re-evaluation/Notes *(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.)*** • **Durable Medical Equipment Receipt Signature Log/Proof of Delivery** • **Proof of Delivery/Signature Logs** • Diagnostic Test Results • Ophthalmology Visit and Progress Notes *(signed and dated)* • Optometry and Optical Visit Notes *(signed and dated)* • Eyeglass/Optician Invoices • Prior Authorization for Durable Medical Equipment Needed for Provision of Therapy Services (*if required*) • **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.*

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
13	**Day Habilitation, Adult Day Care, Foster Care, or Waiver Programs and School-based Services**	**Home and Community-based Services (HCBS), Adult Day Care, Foster Care, or Waiver Services:** • **Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records *(signed and dated, with amount, type, start/stop times, and duration)*** • **Service/Treatment Plan and Goals (*in effect during sampled date/s of service)*** • **Individual Education Plan *(IEP)*; Individual Program Plan *(IPP)*; Individual Service Plan *(ISP)*; Individual Family Service Plan *(IFSP) (in effect during sampled date/s of service)*** • **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.*	• Case Management/Supervisory Visit Notes • DME Signature Log/Proof of Delivery • Prior Authorization *(if required)* • Orders from Identified Qualified Provider *(if required)* Transportation Provider: • Account Ledger and Billing Statements • Ground Mileage/Pick-up and Drop-off Details • Prior Authorization *(if required)*
		School-based Services: • **Individual Education Plan *(IEP)*; Individual Program Plan *(IPP)*; Individual Service Plan *(ISP)*; Individual Family Service Plan*(IFSP) (in effect during sampled date/s of service, include Physician Orders if required)*** • **Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records *(signed and dated, with amount, type, start/stop times, and duration)*** • Orders from Identified Qualified Provider • Psychological Testing, Mental Health Counseling Notes, Treatment Plan, and Progress Toward Goals • Case Management, Skilled Nursing, Social Work, and/or Personal Care Service • **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.*	• Assistive Mobility, Vision, and/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)* • Service/Treatment Plan and Goals (*in effect during sampled date/s of service)* Transportation Provider: • Account Ledger and Billing Statements • Ground Mileage/Pick-up and Drop-off Details
14	**Laboratory, X-ray and Imaging Services**	• **Physician Order Sheet *(signed and dated)*** • **Laboratory Report/Results**	• Radiology/Imaging Report/Results and Interpretation (*please **do not** send x-rays)* • **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.*

Category	Type of Service	Documents Requested (if applicable to sampled claim)	
15	**Outpatient Hospital Services:** • Outpatient • Emergency Svcs	• **Operative and Procedure Reports/Notes** • **Emergency Department Record/Notes** • **Physician Orders and Progress Notes (*signed and dated*)** • Admission Face Sheet/Coding Summary • Admission History and Physical *(H&P)* • Nursing Assessment/Notes • Consultation Reports/Notes • Cardiovascular and Respiratory Reports • Physical and Occupational Therapy Assessments/Notes • Speech Language Pathology *(SLP)* Assessments/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.*	• Ambulance Services • Medication Administration Record *(MAR)* • Dialysis Treatment Record/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 • Discharge Summary • All Transfer Forms • Itemized Billing Sheet (*if required based on payment method*)
16	**Durable Medical Equipment (DME) and Supplies, Prosthetic /Orthopedic Devices, and Environmental Modifications**	• **Physician Orders (*signed and dated; include all relevant orders for the sampled claim*)** • **Durable Medical Equipment/Supplies Prescription (*signed and dated*)** • **Proof of Delivery/Signature Logs *(dated)*** • **Prior Authorization for Devices, Prosthetics, Equipment, Environmental Modifications, and/or Supplies *(if required)*** • **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.*	• Prosthetic/Orthopedic Device Assessments/Notes (*dated*) • 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)*** • **Ground Mileage/Air Mileage Details** • **Starting Point and Destination/Odometer Readings** • **Transportation Log with Member Signature**	• Transportation Schedule for Requested Dates of Service • Physician Order for Transportation/Accommodations (*if applicable)* • Documentation reflecting Medical Necessity for Transportation and Accommodations • Chaperone Documentation, if Appropriate *(approval/authorization)*

Category	Type of Service	Documents Requested (if applicable to sampled claim)
		• **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.*
18	**Denied Claims**	No Documents/Medical Records Requested
19	**Crossover Claims**	No Documents/Medical Records Requested
30	**Capitated Care/Fixed Payments** • Fixed Payments for Primary Care Case Management (PCCM) • Medicare Part A Premiums • Medicare Part B Premiums • Health Insurance Premium Payments (HIPP) • Aggregate Payments	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