

**PLAN NAME:**

- Simply Healthcare Plans (SHP)
- Clear Health Alliance (CHA)
- Better Health (BH)

DATE FORM RECEIVED IN PLAN RM DEPT: \_\_\_\_\_

DATE FORM COMPLETED BY PROVIDER: \_\_\_\_\_

**PROVIDER INCIDENT REPORT FORM**

PURSUANT TO F.S 395.0197 AND 641.55 THIS REPORT IS CONFIDENTIAL DO NOT COPY

**Section 1 Provider/Vendor/Facility Information (To be completed by Facility/Vendor/provider )**

FACILITY/VENDOR/PROVIDER NAME: \_\_\_\_\_ PHONE NO.& EXTENSION: \_\_\_\_\_

OFFICE OR GROUP NAME (IF APPLICABLE): \_\_\_\_\_

STREET ADDRESS/SUITE #: \_\_\_\_\_

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

PROVIDER PLAN ID#: \_\_\_\_\_ OFFICE CONTACT PERSON: \_\_\_\_\_ PHONE NO./EXT: \_\_\_\_\_

RISK MANAGER NAME: \_\_\_\_\_ PHONE NUMBER/EXTENSION: \_\_\_\_\_

RISK MANAGER E-MAIL: \_\_\_\_\_ FAX#: \_\_\_\_\_

**Section 2 Member Information (To be completed by Facility/Vendor/provider )**

LOB:  Medicare  Medicaid

MEMBER NAME: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MEMBER ADDRESS: \_\_\_\_\_ MEMBER PH #: \_\_\_\_\_ GUARDIAN: \_\_\_\_\_

HOSPITAL/FACILITY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ DATE OF ADMISSION: \_\_\_\_\_

ADMITTING DIAGNOSIS: \_\_\_\_\_ ICD-10 CODE: \_\_\_\_\_ INCIDENT DATE/TIME: \_\_\_\_\_

CURRENT DIAGNOSIS: \_\_\_\_\_ ICD-10 CODE: \_\_\_\_\_ (After event/Incident, and if still at facility)

DATE OF DISCHARGE: \_\_\_\_\_ DISCHARGE DIAGNOSIS: \_\_\_\_\_ ICD-10 CODE: \_\_\_\_\_

**Section 3 Incident Information (To be completed by Facility/Vendor/provider )**

- RELATED HEALTH CARE PROVIDER:**
- |  |   |
|--|---|
| <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Laboratory                 |
| <input type="checkbox"/> Physician Office    | <input type="checkbox"/> Ambulatory Surgical Center |
| <input type="checkbox"/> Hospital-IP         | <input type="checkbox"/> Assisted Living Facility   |
| <input type="checkbox"/> Hospital-OP         | <input type="checkbox"/> SNF                        |
| <input type="checkbox"/> Emergency Room      | <input type="checkbox"/> Transportation             |
| <input type="checkbox"/> Home Health         | <input type="checkbox"/> DME                        |
| <input type="checkbox"/> Nursing Home        | <input type="checkbox"/> Behavior Health/Facility   |
| <input type="checkbox"/> Outpatient Facility | <input type="checkbox"/> Other _____                |

- OTHER REPORTABLE CONDITIONS:** \*Medicaid Contract, ATT II, Section VII.F
- Abuse /Neglect/Exploitation (Suspected)\*
  - Delay in Diagnosis/Care/Treatment
  - Medication Incident/Incorrect Administration of Drug\*
  - Hemolytic Blood Transfusion reaction from ABO Incompatibility
  - Intravascular embolism resulting in death/neurological damage
  - Fall/Trip Attended or Unattended
  - Member Death-Suicide in Facility\*
  - Member Death-Homicide in Facility\*
  - Member Attempt- Suicide in Facility\*
  - Member Involvement with Law Enforcement\*
  - Member Elopement/Missing/Escape from facility\*
  - Suspected Unlicensed ALF or AFCH\*
  - Sexual/Physical Assault/Abuse/Battery\*
  - Infant Discharge to wrong family / Child Abduction
  - Altercations in facility requiring medical Intervention\*
  - Transportation Vendor- Vehicle Accident
  - Loss or destruction of enrollee records
- Other: \_\_\_\_\_

An **ADVERSE INCIDENT** is an injury of an enrollee occurring during delivery of Managed Care Plan covered services; that is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and is not consistent with or expected to be a consequence of service provision. It could occur as a result of service provision to which the patient has not given his informed consent; or occur as the result of any other action or lack thereof on the part of the staff of the provider.

- ADVERSE INCIDENT BEING REPORTED:**
- Enrollee death
  - Enrollee brain damage
  - Enrollee spinal damage
  - Permanent disfigurement
  - Fracture or dislocation of bones or joints
  - Any condition requiring definitive or specialized medical attention, which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
  - Any condition requiring surgical intervention to correct or control
  - Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
  - Any condition that extends the enrollee's length of stay
  - Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility

**RISK MANAGEMENT INCIDENT REPORT FORM**

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**Section 3 – Incident Information (Continued)**

**Past Medical History/Diagnoses:**

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**Detailed Incident Description:**

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**Note the names of all personnel and the capacity in which they were involved with this incident:**

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**Action(s) Taken by Facility/Vendor/Provider to Mitigate the Incident:**

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**ICD 10 CM Codes:** (TO BE COMPLETED BY RN or PROVIDER ONLY) if applicable

Surgical, diagnostic or treatment procedure performed at time of incident.(ICD 10 Codes):	Accident, event, circumstances, or specific agent that caused the injury or event.(ICD 10 E-Codes):	Resulting Injury (ICD 10 Codes):
<hr/>	<hr/>	<hr/>

**Full Name of Individual Completing Form:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**RISK MANAGEMENT INCIDENT REPORT FORM**

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***Section 4 Analysis and Corrective Action***

***(To be completed by Plan-RM Staff)***

**Analysis (apparent cause) of this incident:**

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**Describe CAP (corrective action plan) Including timeframes for CAP implementation:**

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**Incident Resolved? If unresolved, explain how it will be resolved:**

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\_\_\_\_\_  
**Signature of Plan Risk Manager**

\_\_\_\_\_  
**Date**

***PROVIDER/FACILITY/VENDOR: Please complete Sections 1, 2, and 3 of this incident form and submit it to [RiskManagement@simplyhealthcareplans.com](mailto:RiskManagement@simplyhealthcareplans.com) via a HIPAA secured e-mail or FAX to 786-441-8218 within 24 hours of discovery of the incident.***

***You may also contact Deborah L. Polynice, Licensed Healthcare Risk Manager at 786.264.0786***