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:**_____

CURENT 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:

[ ] Pharmacy
[ ] Physician Office
[ ] Hospital-IP
[ ] Hospital-OP
[ ] Emergency Room
[ ] Home Health
[ ] Nursing Home
[ ] Outpatient Facility
[ ] Laboratory
[ ] Ambulatory Surgical Center
[ ] Assisted Living Facility
[ ] SNF
[ ] Transportation
[ ] DME
[ ] Behavior Health/Facility
[ ] 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

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

Section 3 – Incident Information (Continued)

Past Medical History/Diagnoses:

_____

_____

Detailed Incident Description:

_____

_____

_____

_____

_____

_____

_____

_____

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

_____ _____

_____ _____

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

_____

_____

_____

_____

_____

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): _____

Full Name of Individual Completing Form: _____ **Title**: _____

Signature: _____ **Date:** _____

RISK MANAGEMENT INCIDENT REPORT FORM

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

Section 4 Analysis and Corrective Action ***(To be completed by Plan-RM Staff)***

Analysis (apparent cause) of this incident:

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____ _____

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 *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