|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Member’s First Name:  Click here to enter Member’s First Name. | | | | Member’s Last Name:  Click here to enter Member’s Last Name. | |
| DOB:  Click to enter DOB. | Medicaid ID#:  Click here to enter Medicaid ID#. | | | Date/Time of Report:  Click to enter date. Click here to enter time. | |
| Date/Time of Incident:  Click to enter date. Click here to enter time. | | | | Incident Discovered Date/Time (ET)  Click to enter date. Click here to enter time. | |
| Member Gender:  Male  Female | | | | Facility Name/Address of Incident (if applicable or known):  Click here to enter Facility Name.  Click here to enter Address Line1.  Click here to enter Address Line2.  Click here to enter City, State, Zip. | |
| Incident Category (see clarification below):  Choose an item. | | | |
| Provider Type:  Provider - Hospital (Name) Click here to enter Hospital Name.  Provider - PCP or Specialist (Name) Click here to enter PCP or Specialist Name.  Provider - Nursing Facility (Name) Click here to enter Nursing Facility Name.  Provider - IP BH Facility (Name) Click here to enter IP BH Facility Name.  Provider - HCBS provider (Name) Click here to enter HCBS Provider Name.  Provider - Other provider (Name) Click here to enter Other Provider Name. | | | | | |
| Brief Description of Incident (e.g. medication error):  Click here to enter Brief Description. | | | Abuse, Neglect, or Exploitation? Yes  No | | |
| Detailed Description of Incident (Use additional sheets, as necessary):  Click here to enter Detailed Description of Incident. | | | | | |
| Cause of Death (if applicable and if known):  Click here to enter Cause of Death. | | | | | |
| Source for Critical Incident Data;  Individual  Family/Caregiver  Provider  MCO Team  Anonymous  APS/CPS  DBHDS/State Agency  Ombudsman   Other | | | | | |
| Contact Name:  Click here to enter Contact Name. | | Contact Phone No.:  Click here to enter Contact Phone. | | | Contact E-Mail:  Click here to enter Contact E-mail. |

*\*All incidents must be reported within 24 hours. Verbal reports must be documented within 48 hours.*

***Clarification****: A* ***Quality of Care*** *incident is defined as any incident that calls into question the competence or professional conduct of a healthcare provider while providing medical services and has adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events. A* ***Sentinel Event*** *is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following: [1] Death, [2} Permanent harm, [3] Severe temporary harm and intervention required to sustain life.*

**PLEASE SEND FORM VIA FAX TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW AND FOLLOWING REPORTING TIMEFRAME REQUIREMENTS.**

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| **CONTACT INFORMATION** | | |
| **COMMONWEALTH COORDINATED CARE PLUS PLAN** | **PHONE NUMBER** | **FAX NUMBER** |
| Aetna Better Health of Virginia | (855) 652-8249 | (844) 203-0020 |
| Anthem Healthkeepers Plus | (855) 323-4687 | (855) 273-6831 |
| Magellan Complete Care of Virginia | (800) 424-4524  (TTY 711) | (423) 591-9525  (866) 325 9157 |
| Optima Health Community Care | (757) 552-8398 (866) 546-7924 | (844) 552-7508 |
| United Healthcare | (800) 391-3991 | (855) 371-7638 |
| Virginia Premier Health Plans | (877) 719-7358,  option 1-3-1-1 | (804) 200-1962 |