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 Name**_____

DATE(s) of SERVICE:_____

IF HOSPITAL/FACILITY:

DATE OF ADMISSION: _____ _____**ADMITTING DIAGNOSIS:** _____ **ICD-10 CODE(s)**_____

CURENT DIAGNOSIS:_____ **ICD-10 Code(s):**_____**(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)

INCIDENT DATE:_____**TIME:**_____

RELATED HEALTH CARE PROVIDER:

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

INCIDENT BEING REPORTED: (*Medicaid Contract, ATT II, Section VII.F)

□ Abuse /Neglect/Exploitation (Suspected)*
□ Delay in Diagnosis/Care/treatment
□ Medication Incident/Incorrect Adm of Drug*
□ Fall/Trip Attended or Unattended
□Mbr Death-Suicide in Facility*
□ Mbr Death-Homicide in Facility*
□ Mbr 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*
□Other:_____

SENTINEL/ADVERSE EVENTS: Adverse Event is defined as an unexpected event involving death or serious physical or psychological injury or the risk thereof during a healthcare encounter which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Please indicate the Sentinel/Adverse event being reported:

□ Unexpected Death/Fetal Death
□ Severe Brain/Spinal Damage
□ Serious Physical and psychological Injury
□ Performance of surgical procedure on wrong patient or wrong side.
□ Wrong surgical procedure performed
□ Surgical repair of injuries from a planned surgical procedure.
□ Surgical Procedure unrelated to diagnosis
□ Suicide in an inpatient unit
□ Performance of procedure to remove unplanned foreign Objects remaining from previous surgery
□ Surgery Complication □ Unplanned transfer to ICU
□ Unplanned Return to Surgery

Note:
If the incident involved a death, was the Medical Examiner notified? □ **Yes** □ **No** Was an autopsy performed? □ **Yes** □**No**
MEDICAL EXAMINER NAME: _____
TELEPHONE NUMBER: _____

DO NOT PHOTOCOPY

RISK MANAGEMENT INCIDENT REPORT FORM

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

Detailed Incident Description:

_____

_____

_____

_____

_____

_____

Equipment Involved in Incident:

_____

_____

_____

Name and License numbers of all personnel and capacity in which they were directly involved with this incident. List SS# numbers and capacity of unlicensed personnel involved with the incident (I.e. ER, physician, attending physician, surgeon, etc.)

_____ _____

_____ _____

License number of witnesses or SS# of unlicensed witnesses:

_____ _____

_____ _____

Action Taken by Facility/Vendor/Provider to try to Mitigate Issue:

_____

_____

_____

_____

_____

ICD 9/ICD 10 CM Codes: *(TO BE COMPLETED BY RN or PROVIDER ONLY) if applicable*

Surgical, diagnostic, or treatment procedure being performed at time of incident. (ICD 9 or 10 Codes 01-99.9) : _____	Accident, event, circumstances, or specific agent that caused the injury or event . (ICD 9 or 10 E-Codes) _____	Resulting Injury (ICD9 or 10 Codes 800-999.9) _____

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

Signature:_____ **Date:**_____

DO NOT PHOTOCOPY

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 **Title** **Date**

PROVIDER/FACILITY/VENDOR: *Please fully completed Sections 1, 2 and 3 of this Incident Form and submit it immediately, never more than 24 hours from the date/time of the incident, to the Plan's Risk Management Department via HIPAA Secure E-mail as follows to* RiskManagment@Simplyhealthcareplans.com

Risk Manager: Deborah Polynice, LHCRM **E-MAIL:** dpolynice@simplyhealthcareplans.com **You may also call:** 786-264-0786.