Adverse Events Reporting Form

This form must be received within 48 hours of discovery of event. Failure to comply with reporting requirements may result in corrective action.

You must review the entire form and fill out sections that are applicable to the situation you are reporting. Please attach medical records if available.

Completed forms should be sent to your Provider Network Development Representative, who can also be contacted with any questions or concerns regarding completing the form.

Section 1: Patient Information (Complete All Sections)		
Member Name:	Date of Birth:	Gender:
Last 4 of SSN:	Member Medicaid/Medicare ID (if applicable):	

Section 2: Adverse Event Details (Complete All Sections)
Incident Date & Time:
Incident Location: ☐Hospital ☐Assisted Living Facility ☐Urgent Care ☐Nursing Home ☐Healthcare Provider Office ☐Other:_____ **Address, City, State, Zip Code:**
Incident Narrative: *Document: Who was involved, description of incident, witnesses ,etc.*

Section 3: Resolution/Conclusion
Actions Taken to Mitigate Risk to Patient

Section 4: Reporter Information	
Provider Name & NPI:	**Address, City, State, Zip Code:**
Telephone Number:	**Email Address:**