

### Provider Incident Report Form

*This form is pursuant to F.S. 395.0197 and 641.55. This report is confidential. Do not copy.*

Plan name: Amerigroup      Product(s): Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA)/ Florida Healthy Kids (FHK)/comprehensive (SMMC MMA and LTC)

Date form received in plan Risk Management department: \_\_\_\_\_ Date form completed by provider: \_\_\_\_\_

**Section 1 — provider/vendor/facility information (to be completed by provider/vendor/facility)**

Provider/vendor/facility name: \_\_\_\_\_ Phone #/extension: \_\_\_\_\_  
 Office or group name (if applicable): \_\_\_\_\_  
 Street address/suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Provider plan ID #: \_\_\_\_\_ Office contact person: \_\_\_\_\_ Phone #/extension: \_\_\_\_\_  
 Risk manager name: \_\_\_\_\_ Phone #/extension: \_\_\_\_\_  
 Risk manager email: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Section 2 — member information (to be completed by provider/vendor/facility)**

Line of business:  SMMC MMA     FHK     Comprehensive (SMMC MMA and LTC)  
 Member name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Member address: \_\_\_\_\_ Member phone #: \_\_\_\_\_ 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 provider/vendor/facility)**

<p><b>Related health care provider:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Pharmacy</td> <td><input type="checkbox"/> Laboratory</td> </tr> <tr> <td><input type="checkbox"/> Physician office</td> <td><input type="checkbox"/> Ambulatory surgical center</td> </tr> <tr> <td><input type="checkbox"/> Hospital — inpatient</td> <td><input type="checkbox"/> Assisted living facility</td> </tr> <tr> <td><input type="checkbox"/> Hospital — outpatient</td> <td><input type="checkbox"/> Skilled nursing facility</td> </tr> <tr> <td><input type="checkbox"/> ER</td> <td><input type="checkbox"/> Transportation</td> </tr> <tr> <td><input type="checkbox"/> Home health</td> <td><input type="checkbox"/> Durable medical equipment</td> </tr> <tr> <td><input type="checkbox"/> Nursing home</td> <td><input type="checkbox"/> Behavior health/facility</td> </tr> <tr> <td><input type="checkbox"/> Outpatient facility</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p><b>Other reportable conditions:</b> * Medicaid contract, ATT II, section VII.F</p> <p><input type="checkbox"/> Abuse/neglect/exploitation (suspected)*  <input type="checkbox"/> Delay in diagnosis/care/treatment  <input type="checkbox"/> Medication incident/incorrect administration of drug*  <input type="checkbox"/> Hemolytic blood transfusion reaction from ABO incompatibility  <input type="checkbox"/> Intravascular embolism resulting in death/neurological damage  <input type="checkbox"/> Fall/trip attended or unattended  <input type="checkbox"/> Member death — suicide in facility*  <input type="checkbox"/> Member death — homicide in facility*  <input type="checkbox"/> Member attempt — suicide in facility*  <input type="checkbox"/> Member involvement with law enforcement*  <input type="checkbox"/> Member elopement/missing/escape from facility*  <input type="checkbox"/> Suspected unlicensed ALF or AFCH*  <input type="checkbox"/> Sexual/physical assault/abuse/battery*  <input type="checkbox"/> Infant discharge to wrong family/child abduction  <input type="checkbox"/> Altercations in facility requiring medical intervention*  <input type="checkbox"/> Transportation vendor — vehicle accident  <input type="checkbox"/> Loss or destruction of enrollee records    Other: _____</p>	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Physician office	<input type="checkbox"/> Ambulatory surgical center	<input type="checkbox"/> Hospital — inpatient	<input type="checkbox"/> Assisted living facility	<input type="checkbox"/> Hospital — outpatient	<input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> ER	<input type="checkbox"/> Transportation	<input type="checkbox"/> Home health	<input type="checkbox"/> Durable medical equipment	<input type="checkbox"/> Nursing home	<input type="checkbox"/> Behavior health/facility	<input type="checkbox"/> Outpatient facility	<input type="checkbox"/> Other: _____	<p>An <b>adverse incident</b> 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 informed consent or occur as the result of any other action or lack thereof on the part of the staff of the provider.</p> <p><b>Adverse incident being reported:</b></p> <p><input type="checkbox"/> Enrollee death  <input type="checkbox"/> Enrollee brain damage  <input type="checkbox"/> Enrollee spinal damage  <input type="checkbox"/> Permanent disfigurement  <input type="checkbox"/> Fracture or dislocation of bones or joints  <input type="checkbox"/> Any condition requiring definitive or specialized medical attention that is not consistent with the routine management of the patient’s case or patient’s pre-existing physical condition  <input type="checkbox"/> Any condition requiring surgical intervention to correct or control  <input type="checkbox"/> Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care  <input type="checkbox"/> Any condition that extends the enrollee’s length of stay  <input type="checkbox"/> Any condition resulting in a limitation of neurological, physical or sensory function that continues after discharge from the facility</p>
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Laboratory																
<input type="checkbox"/> Physician office	<input type="checkbox"/> Ambulatory surgical center																
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<input type="checkbox"/> Nursing home	<input type="checkbox"/> Behavior health/facility																
<input type="checkbox"/> Outpatient facility	<input type="checkbox"/> Other: _____																

**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 provider/vendor/facility to mitigate the incident:**

**ICD-10-CM codes if applicable (to be completed by RN or provider only):**

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): _____
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**Full name of individual completing form:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

**Section 4 — analysis and corrective action (to be completed by plan Risk Management staff)**

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

**Equipment involved in the incident:**

**Witnesses to the incident:**

**Was the member's PCP notified?**

**PCP's recommendations if any:**

**Describe corrective action plan (CAP) including time frames for CAP implementation:**

**Was the 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 ClinicalRiskMgt@amerigroup.com via a HIPAA-secured email **within 48 hours** of discovery of the incident.

You may also contact Maria Satchell-Rahman, licensed health care risk manager, at 813-523-0992.