Amerigroup RealSolutions in healthcare

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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 Long-Term Care (SMMC 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 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)

Related health care provider:

[ ] Pharmacy
[ ] Physician office
[ ] Hospital — inpatient
[ ] Hospital — outpatient
[ ] ER
[ ] Home health
[ ] Nursing home
[ ] Outpatient facility
[ ] Laboratory
[ ] Ambulatory surgical center
[ ] Assisted living facility
[ ] Skilled nursing facility
[ ] Transportation
[ ] Durable medical equipment
[ ] 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 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 that is not consistent with the routine management of the patient's case or patient's pre-existing 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 resulting in a limitation of neurological, physical or sensory function that continues after discharge from the facility

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): _____

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 24 hours** of discovery of the incident.

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