# *Provider Incident Report Form*

*This communication applies to the Medicaid programs for Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) as well as the Florida Healthy Kids (FHK) and the Medicare Advantage program for Simply.*

## Pursuant to F.S 395.0197 and 641.55, this report is confidential. Do not copy.

| | | |
|---|---|---|
| ☐ Simply | Date form received: | |
| ☐ CHA | Record number: | |

## Section 1: Provider/vendor/facility information (to be completed by provider/vendor/facility)

| | | |
|---|---|---|
| Provider/vendor/facility name: | | Phone: |
| Office or group name (if applicable): | | Provider plan ID: |
| Address: | | |
| Office contact person: | | Phone: |
| Risk manager name: | | Phone: |
| Risk manager email: | | Fax: |

## Section 2: Member information (to be completed by provider/vendor/facility)

**Line of business:** ☐ Medicare Advantage ☐ Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA) ☐ Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) ☐ FHK ☐ Comprehensive (MMA and LTC) ☐ CHA

| | | | |
|---|---|---|---|
| Member name: | | Member ID: | Gender: |
| DOB: | Member Phone #: | Parent/guardian: | |
| Member address: | | County: | |
| (If hospitalized) hospital name: | | Phone #: | |
| Address: | | | |
| Admission date: | Primary admitting diagnosis: | | ICD-10 code: |
| Date of incident: | (If applicable) name of provider who caused incident: | | |
| Provider address: | | Provider phone #: | |
| Name of PCP: | | PCP phone #: | |

## Section 3: Incident information (to be completed by provider/vendor/facility)

| Type of facility or healthcare provider: | | An **adverse incident** is an **injury** of an enrollee **occurring during delivery of 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 |
|---|---|---|
| ☐ Pharmacy | ☐ Clinic | |
| ☐ Physician office | ☐ Ambulatory surgical center | |
| ☐ Hospital – IP | ☐ Assisted living facility (ALF) | |
| ☐ Hospital – OP | ☐ Skill nursing facility | |
| ☐ Emergency room | ☐ Transportation | |

| | | |
|---|---|---|
| ☐ Home health<br>☐ Nursing home<br>☐ Outpatient facility<br>☐ Plan internal issue | ☐ DME<br>☐ Behavioral health facility<br>☐ Laboratory<br>☐ Other: | consent or **occur as the result of any other action or lack thereof on the part of the staff of the provider**. |

| **Incident being reported** | **Incident being reported** |
|---|---|
| ☐ Abuse ☐ Neglect ☐ Exploitation (suspected)*<br>☐ Delay in diagnosis ☐ Care/treatment<br>☐ Medication incident ☐ Incorrect administration of drug*<br>☐ Fall — ☐ With injury ☐ Without injury ☐ Attended ☐ Unattended<br>☐ Member death: suicide in facility*<br>☐ Member death: homicide in facility*<br>☐ Member attempt: suicide in facility*<br>☐ Member involvement with law enforcement*<br>☐ Member elopement ☐ Missing ☐ Escape from facility*<br>☐ Suspected unlicensed ALF or Adult Family Care Home *<br>☐ Sexual ☐ Physical assault ☐ Abuse ☐ Battery*<br>☐ Loss or destruction of enrollee records<br>☐ Maternal death ☐ Serious morbidity associated with labor and delivery<br>☐ Intravascular embolism resulting in death ☐ Neurological damage<br>☐ Hemolytic blood transfusion reaction from ABO incompatibility<br>☐ Infant discharge to wrong family ☐ Child abduction<br>☐ Altercations in facility requiring medical intervention*<br>☐ Transportation vendor — vehicle accident<br>☐ Other: | ☐ Unexpected death ☐ Fetal death<br>☐ Severe brain damage ☐ Spinal damage<br>☐ Serious physical and psychological injury<br>☐ Performance of surgical procedure on wrong patient or wrong side<br>☐ Wrong surgical procedure performed<br>☐ Surgical repair of injuries from a planned surgical procedure<br>☐ Surgical procedure unrelated to diagnosis<br>☐ Suicide in an inpatient unit<br>☐ Performance of procedure to remove unplanned foreign objects remaining from previous surgery<br>☐ Surgery complication<br>☐ Unplanned transfer to ICU<br>☐ Unplanned return to surgery |
| **Past medical history/diagnoses:** | |
| **Detailed incident description:** | |

**Was incident preventable?** ☐ Yes ☐ No
If yes, how could the incident have been prevented?

**Note the names of all personnel and the capacity in which they were directly involved in this incident:**

**Action(s) taken by provider/vendor/facility to mitigate the incident:**

**ICD-10-CM codes (to be completed by RN or provider only) if applicable:**
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: |
|---|---|
| Name of organization: | |
| Signature: | Date: |

## Section 4: Analysis and corrective action (to be completed by plan Risk Management staff)

Submit SMMC MMA, FHK, and Simply and CHA incidents within 48 hours of discovery. Submit SMMC LTC incidents within 24 hours of discovery via a *HIPAA* secured online portal to **https://provider.simplyhealthcareplans.com/florida-provider** for Simply providers or **https://provider.clearhealthalliance.com/florida-provider** for CHA providers.

In lieu of submitting the report through the online portal, providers/vendors may submit the completed form via a *HIPAA* secured email to riskmanagement@simplyhealthcareplans.com.

Providers/vendors may also contact:
- Deborah L. Polynice, Certified Professional Healthcare Risk Manager:
  - dpolynice@simplyhealthcareplans.com
  - **786-423-3691**
- Maria Satchell, Healthcare Risk Manager:
  - maria.satchell@anthem.com
  - **813-523-0992**
- Graciela Gonzalez-Ebrahimi, GBD Manager II:
  - LucyGonzalez-Ebrahimi@simplyhcp.com