Simply Healthcare Plans, Inc.
Clear Health Alliance
Medicaid Managed Care

Risk Management Incident Report Form

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

☐ Simply Healthcare Plans, Inc.	Date form received:
☐ Clear Health Alliance	Case ID:

Section 1: Referring employee demographics

Prepared by:	Phone:	Date initiated:
☐Member Services ☐Health Services/UM/Case Management ☐Grievances and Appeals ☐Quality Management ☐Compliance ☐Provider Administration ☐Other:		

Section 2: Member, provider and facility information

Line of business:
☐Medicare Advantage ☐Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA) ☐Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) ☐Florida Healthy Kids ☐Comprehensive (SMMC MMA and SMMC LTC)

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

Section 3: Incident information

Type of facility or health care provider:	
☐Pharmacy	☐Clinic
☐Physician office	☐Ambulatory surgical center
☐Hospital — IP	☐Assisted living facility (ALF)
☐Hospital — OP	☐Skilled nursing facility
☐Emergency room	☐Transportation
☐Home health	☐DME
☐Nursing home	☐Behavioral health facility
☐Outpatient facility	☐Laboratory
☐Plan internal issue	☐Other:

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 consent, **or occur as the result of any other action or lack thereof on the part of the staff of the provider**.

https://provider.simplyhealthcareplans.com/florida-provider
https://provider.clearhealthalliance.com/florida-provider

Incident being reported (* Medicaid Contract, ATT II, Section VII.F)	**Incident being reported**
☐Abuse ☐Neglect ☐Exploitation (Suspected)* ☐Delay in diagnosis ☐Care/treatment ☐Medication incident ☐Incorrect administration of drug* ☐Fall — ☐With injury ☐Without injury ☐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 adult family care home* ☐Sexual ☐Physical assault ☐Abuse ☐Battery* ☐Loss or destruction of enrollee records ☐Serious morbidity associated with labor and delivery ☐Maternal death ☐Neurological damage ☐Intravascular embolism resulting in death ☐Hemolytic blood transfusion reaction from ABO incompatibility ☐Infant discharge to wrong family ☐Child abduction ☐Altercations in facility requiring medical intervention* ☐Transportation vendor — vehicle accident ☐Other:	☐Unexpected death ☐Fetal death ☐Severe brain damage ☐Spinal damage ☐Serious physical and psychological injury ☐Wrong surgical procedure performed ☐Surgical procedure unrelated to diagnosis ☐Suicide in an inpatient facility ☐Surgery complication ☐Unplanned transfer to ICU ☐Unplanned return to surgery ☐Performance of surgical procedure on wrong patient or wrong side ☐Surgical repair of injuries from a planned surgical procedure ☐Performance of procedure to remove unplanned foreign objects remaining from previous surgery
A. Past medical history/diagnoses:	
B. Detailed incident description:	
C. Note the names of all personnel and the capacity in which they were directly involved in this incident:	
D. Referral submitted to Quality Management: ☐Yes ☐No	
E. For case managers: Was a physician called?: ☐Yes ☐No If the case manager called the member's physician, give a brief statement of said physician's recommendation as to the medical treatment, if any:	

Section 4: Risk Management (RM) analysis (to be completed by plan RM staff)

Analysis (apparent cause) of this incident:		
Equipment involved in the incident:		
Names of personnel and witnesses and the capacity in which they were involved in the incident:		
Member's provider was notified: ☐Yes ☐No		
If a physician was called, give a brief statement of said physician's recommendations as to the medical treatment, if any:		
Describe *Corrective Action Plan* (*CAP*) that includes time frames for *CAP* implementation:		
Incident resolved: ☐Yes ☐No If unresolved, explain how it will be resolved:		
Adverse incident: ☐Yes ☐No	Reportable to AHCA: ☐Yes ☐No	
Critical incident type: ☐MMA ☐LTC	Reported to DCF: ☐Yes ☐No	Date reported:

Signature of risk manager:	**Date:**

Please complete Sections 1, 2 and 3 of this incident form.

Submit forms to Risk Management:
RiskManagement@simplyhealthcareplans.com

If you have questions, contact:

- Deborah L. Polynice, Licensed Healthcare Risk Manager:
  - dpolynice@simplyhealthcareplans.com
  - **1-786-423-3691**
- Maria Satchell, Licensed Healthcare Risk Manager:
  - maria.satchell-rahman@amerigroup.com
  - **1-813-523-0992**
- Lila Labarces, Dir II Quality Management:
  - llabarces@simplyhealthcareplans.com

Note: Failure to report timely may subject the plan to Agency for Health Care Administration (AHCA) imposed fines, sanctions and liquidated damages.