**Healthy Louisiana**

**Adverse Incident Reporting Form**

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| The provider **must** fax this form or any form with the necessary information to the appropriate health plan of the member addressed below **within 1 business day** of discovery of the incident.  **ABH: 860-262-9174 ACLA: 844-341-7641 Healthy Blue: 855-859-5044**  **LHCC: 866-704-3063 UHC: 877-554-3362 Humana: 888-305-7974** |

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| --- | --- |
| Member Name: | Diagnosis: |
| Member Number: | Provider Level of care: |
| Member Date of Birth: | Incident Location: |
| Legal Status: | Date and Time of Incident: |
| Date Form Completed: | Date Incident Discovered: |

Select any of the following categories that were involved.

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|  | Abuse |  | Exploitation |
|  | Neglect |  | Death |
|  | Extortion |  |  |

Description of Event: (including specifics on incident, using as many pages as necessary, numbering, dating, and signing each)

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Action taken to ensure safety of all involved: (including debriefing efforts and steps to avoid similar future events)

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Select the appropriate boxes that apply.

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|  | Parent/Guardian notified |  | Date/Person notified: |
|  | Law enforcement/Protective services notified (if applicable) |  | If yes, agency and contact information: |
|  | Member seen by psychiatrist, physician or nurse after incident |  | If yes, treatment: |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_