

Iowa Medicaid Critical Incident Report

Please note: Select **Completed** ONLY when all investigative activities are complete and resolution activities have been implemented. Otherwise submit an initial report. Report Status: Initial Completed

Reporting Party	National Provider Identifier _____ Provider (Name or Agency) _____ Provider Address _____ City _____ State _____ Zip _____ County _____ Phone # _____ Fax # _____ Reporter Name (Last) _____ (First) _____ (MI) _____ (Title) _____ (Email) _____		
Medicaid Member	Medicaid No. _____ Name (Last) _____ (First) _____ (MI) _____ Address _____ City _____ State _____ Zip _____ County _____ Date of Birth _____ Member's Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Case Manager Name (Last) _____ (First) _____ (Email) _____		HCBS Waiver: <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> III & Handicapped <input type="checkbox"/> Brain Injury <input type="checkbox"/> Physical Disability <input type="checkbox"/> Elderly <input type="checkbox"/> Children's Mental Health <input type="checkbox"/> Intellectually Disabled (formerly MR) State Plan: <input type="checkbox"/> Habilitation Grants: <input type="checkbox"/> MFP
Incident Information	Date of Incident _____ Time of Incident _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unknown The Incident Was: <input type="checkbox"/> Discovered <input type="checkbox"/> Witnessed First staff person to learn of the incident (Name) _____ (Title) _____ Location where incident occurred (select one): <input type="checkbox"/> Member's Home <input type="checkbox"/> Private residence/household – living alone <input type="checkbox"/> Private residence/household – living with relatives <input type="checkbox"/> Private residence/household – living with unrelated persons <input type="checkbox"/> Community supervised living <input type="checkbox"/> RCF <input type="checkbox"/> RCF/MR <input type="checkbox"/> RCF/PMI <input type="checkbox"/> Assisted living <input type="checkbox"/> Other _____ <input type="checkbox"/> Community <input type="checkbox"/> Community job <input type="checkbox"/> School <input type="checkbox"/> Day program <input type="checkbox"/> Work activity <input type="checkbox"/> Homeless/shelter/street <input type="checkbox"/> Vehicle <input type="checkbox"/> Shopping <input type="checkbox"/> Dining <input type="checkbox"/> Recreating <input type="checkbox"/> Other _____ <input type="checkbox"/> Other Location <input type="checkbox"/> State MHI <input type="checkbox"/> State resource center <input type="checkbox"/> Correctional facility/jail <input type="checkbox"/> Foster care/family life home <input type="checkbox"/> ICF/nursing facility <input type="checkbox"/> ICF/MR <input type="checkbox"/> ICF/PMI <input type="checkbox"/> Hospital/medical clinic <input type="checkbox"/> Other _____		
	Other People Present (<i>Provide name of person, initials if a member, and their relationship to the member</i>) 1. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 2. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 3. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 4. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____		
	Services (select one): <input type="checkbox"/> Services were not being provided. <input type="checkbox"/> Service being provided at the time of the incident: W code _____ Service Name _____		
	Describe the incident, including Who, What, When, Where, and How . (<i>Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Include what was observed or heard. Attach additional pages if needed.</i>) 		
Immediate Resolution	Date of Immediate Resolution _____ Type of Immediate Resolution (select all that apply): <input type="checkbox"/> Resolved by provider staff <input type="checkbox"/> In-patient hospitalization (medical unit) <input type="checkbox"/> Resolved by case manager <input type="checkbox"/> Incarceration <input type="checkbox"/> Resolved by outside entity <input type="checkbox"/> Resolved by natural supports <input type="checkbox"/> Out-patient mental health <input type="checkbox"/> Treatment by a health care professional <input type="checkbox"/> Emergency room treatment <input type="checkbox"/> In-patient hospitalization (mental health unit)		
	Describe the actions taken after the incident occurred to secure the member's safety. 		
	Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No	Guardian Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attempted, unable to reach	

Physical Injury <input type="checkbox"/>	Please note: Complete the Circumstances section and Physical Injury Type before completing the Injury due to section.		
	Circumstances (select one): Physical injury occurred <input type="checkbox"/> to the member <input type="checkbox"/> by the member to another individual.		
Physical Injury Type: Physical injury requiring physician's treatment or admission to a hospital. (Select all that apply.) <input type="checkbox"/> Burn <input type="checkbox"/> Dislocation <input type="checkbox"/> Sprain <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion/bruise <input type="checkbox"/> Human/animal bite <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture wound <input type="checkbox"/> Fracture <input type="checkbox"/> Electric shock <input type="checkbox"/> Eye emergency <input type="checkbox"/> Loss/tearing of body part <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Poisoning/toxin ingestion <input type="checkbox"/> Other _____	Injury due to (select all that apply): <input type="checkbox"/> Mechanical restraint <input type="checkbox"/> Mechanical restraint for behaviors <input type="checkbox"/> Removal of mobility aids <input type="checkbox"/> Impair sensory capabilities <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Personal harm <input type="checkbox"/> Aggressive behavior <input type="checkbox"/> Self-mutilation/self-injurious behavior <input type="checkbox"/> Suicide attempt <input type="checkbox"/> PICA behavior/ingestion of harmful substance <input type="checkbox"/> Accidental fall <input type="checkbox"/> Aspiration/choking <input type="checkbox"/> Seizure <input type="checkbox"/> Vehicular accident <input type="checkbox"/> Assault <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Medication variance by staff <input type="checkbox"/> Wrong dosage <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong time <input type="checkbox"/> Documentation error <input type="checkbox"/> Unauthorized administration <input type="checkbox"/> Missed dosage <input type="checkbox"/> Other; describe _____	<input type="checkbox"/> Physical/manual restraint <input type="checkbox"/> Movement inhibited <input type="checkbox"/> Take down <input type="checkbox"/> Prone restraint <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Environmental condition <input type="checkbox"/> Fire <input type="checkbox"/> Tornado/storm <input type="checkbox"/> Flooding <input type="checkbox"/> Unsafe/unhealthy physical environment <input type="checkbox"/> Social environment <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Medication variance by member <input type="checkbox"/> Wrong dosage <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong time <input type="checkbox"/> Unauthorized administration <input type="checkbox"/> Missed dosage <input type="checkbox"/> Other; describe _____	
Death <input type="checkbox"/>	Apparent cause of death (select one): <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide/violence <input type="checkbox"/> Terminal illness/natural causes <input type="checkbox"/> Physical injury condition/situation <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Death of person other than member: Name _____ Relationship to member _____	Member's location at time of death (select one): <input type="checkbox"/> Member's legal residence <input type="checkbox"/> Community <input type="checkbox"/> Community job <input type="checkbox"/> School <input type="checkbox"/> Crisis stabilization <input type="checkbox"/> Day program <input type="checkbox"/> Work activity <input type="checkbox"/> State facility <input type="checkbox"/> Hospital/clinic <input type="checkbox"/> Hospice <input type="checkbox"/> Other; describe _____	Physical address where the member died: Address _____ City _____ State _____ Zip _____ Physical illnesses/conditions were: <input type="checkbox"/> Diagnosed prior to death <input type="checkbox"/> Discovered at time of death <input type="checkbox"/> Unknown Complete if known: Was an autopsy requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Was there a DNR order? <input type="checkbox"/> Yes <input type="checkbox"/> No
Death <input type="checkbox"/>	Specifically, what were the circumstances surrounding death?		
Mental Health <input type="checkbox"/>	Emergency mental health treatment due to (select all that apply): <input type="checkbox"/> Condition/situation identified under physical injury <input type="checkbox"/> Condition/situation identified under law enforcement <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Self-injurious/self-mutilation behavior without physical injury <input type="checkbox"/> Aggressive behavior toward another without physical injury <input type="checkbox"/> Other; describe _____		
Law Enforcement <input type="checkbox"/>	Intervention of law enforcement for (indicate whether the member was the victim or perpetrator and select all that apply): <input type="checkbox"/> Illegal sexual behavior; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Possession of illegal/hazardous substances; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Inappropriate sexual advances; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Aggressive behavior; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Illegal acts; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Property damage; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Provoking incident; <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other; describe _____ <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator		
Abuse Report or Restriction <input type="checkbox"/>	Please specify member's involvement: Member was the <input type="checkbox"/> victim <input type="checkbox"/> perpetrator	Report of suspected dependent adult abuse (select all that apply): <input type="checkbox"/> Physical injury <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Self-denial of critical care <input type="checkbox"/> Exploitation <input type="checkbox"/> Denial of critical care	
Abuse Report or Restriction <input type="checkbox"/>	Report of suspected child abuse (select all that apply): <input type="checkbox"/> Physical injury <input type="checkbox"/> Mental injury <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Denial of critical care <input type="checkbox"/> Presence of illegal drugs <input type="checkbox"/> Manufacture or possession of a dangerous substance <input type="checkbox"/> Cohabitation with a registered sex offender	Restriction or confinement (select all that apply): <input type="checkbox"/> Arrest <input type="checkbox"/> As identified under physical injury <input type="checkbox"/> PRN meds for behavior <input type="checkbox"/> Exclusionary timeout <input type="checkbox"/> Seclusion/isolation <input type="checkbox"/> Rights violation <input type="checkbox"/> Cruel punishment	
Location Unk <input type="checkbox"/>	Member's location is unknown by provider responsible for protective oversight. Please describe:		

Incident-Specific Resolutions

<p>Staff Review</p> <input type="checkbox"/>	<p>Please note: Complete the Staff Review section only if staff issues contributed to the incident.</p>															
	<p>Review staff (select all that apply):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Increase number of staff</td> <td><input type="checkbox"/> Disciplinary action</td> </tr> <tr> <td><input type="checkbox"/> Increase staff hour</td> <td><input type="checkbox"/> Change staff</td> </tr> <tr> <td><input type="checkbox"/> Improve team building</td> <td><input type="checkbox"/> Terminate staff</td> </tr> <tr> <td><input type="checkbox"/> Increase supervision of staff</td> <td><input type="checkbox"/> Other; describe _____</td> </tr> </table> <p>Provide staff training on (select all that apply):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Rights</td> </tr> <tr> <td><input type="checkbox"/> Individual needs</td> </tr> <tr> <td><input type="checkbox"/> Behavioral needs</td> </tr> <tr> <td><input type="checkbox"/> Positive and supportive relationships</td> </tr> <tr> <td><input type="checkbox"/> Communication with member, family and/or other staff</td> </tr> <tr> <td><input type="checkbox"/> Staff trained/retrained on equipment use</td> </tr> <tr> <td><input type="checkbox"/> Other; describe _____</td> </tr> </table>	<input type="checkbox"/> Increase number of staff	<input type="checkbox"/> Disciplinary action	<input type="checkbox"/> Increase staff hour	<input type="checkbox"/> Change staff	<input type="checkbox"/> Improve team building	<input type="checkbox"/> Terminate staff	<input type="checkbox"/> Increase supervision of staff	<input type="checkbox"/> Other; describe _____	<input type="checkbox"/> Rights	<input type="checkbox"/> Individual needs	<input type="checkbox"/> Behavioral needs	<input type="checkbox"/> Positive and supportive relationships	<input type="checkbox"/> Communication with member, family and/or other staff	<input type="checkbox"/> Staff trained/retrained on equipment use	<input type="checkbox"/> Other; describe _____
<input type="checkbox"/> Increase number of staff	<input type="checkbox"/> Disciplinary action															
<input type="checkbox"/> Increase staff hour	<input type="checkbox"/> Change staff															
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<input type="checkbox"/> Staff trained/retrained on equipment use																
<input type="checkbox"/> Other; describe _____																
	<p><input type="checkbox"/> Resolution following staffing review/training. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> No staffing changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>															
<p>Member Review</p> <input type="checkbox"/>	<p>Please note: Complete the Member Review section only if member issues contributed to the incident.</p>															
	<p>Review member (select all that apply):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to behavioral issues</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised to reflect member's goals</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to cognitive abilities</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to communication needs</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to physical abilities</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to level of need and support</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to medical/health status, including medication review</td> </tr> <tr> <td><input type="checkbox"/> Treatment plan reviewed and/or revised due to unidentified risk or safety issues; safety plan reviewed/modified</td> </tr> <tr> <td><input type="checkbox"/> Other; describe _____</td> </tr> </table>	<input type="checkbox"/> Treatment plan reviewed and/or revised due to behavioral issues	<input type="checkbox"/> Treatment plan reviewed and/or revised to reflect member's goals	<input type="checkbox"/> Treatment plan reviewed and/or revised due to cognitive abilities	<input type="checkbox"/> Treatment plan reviewed and/or revised due to communication needs	<input type="checkbox"/> Treatment plan reviewed and/or revised due to physical abilities	<input type="checkbox"/> Treatment plan reviewed and/or revised due to level of need and support	<input type="checkbox"/> Treatment plan reviewed and/or revised due to medical/health status, including medication review	<input type="checkbox"/> Treatment plan reviewed and/or revised due to unidentified risk or safety issues; safety plan reviewed/modified	<input type="checkbox"/> Other; describe _____						
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<input type="checkbox"/> Other; describe _____																
	<p><input type="checkbox"/> Resolution following member review. Describe specifically how revision(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Treatment plan reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>															
<p>Equip & Supplies Review</p> <input type="checkbox"/>	<p>Please note: Complete the Equipment & Supplies Review section only if their presence, absence, and/or condition contributed to the incident.</p>															
	<p>Review of equipment and/or supplies (select all that apply):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Necessary equipment needs to be repaired</td> <td><input type="checkbox"/> Necessary equipment needs to be replaced</td> </tr> <tr> <td><input type="checkbox"/> Necessary equipment needs to be purchased</td> <td><input type="checkbox"/> Other; describe _____</td> </tr> </table>	<input type="checkbox"/> Necessary equipment needs to be repaired	<input type="checkbox"/> Necessary equipment needs to be replaced	<input type="checkbox"/> Necessary equipment needs to be purchased	<input type="checkbox"/> Other; describe _____											
<input type="checkbox"/> Necessary equipment needs to be repaired	<input type="checkbox"/> Necessary equipment needs to be replaced															
<input type="checkbox"/> Necessary equipment needs to be purchased	<input type="checkbox"/> Other; describe _____															
	<p><input type="checkbox"/> Resolution following equipment and supplies review. Describe specifically how this review(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Equipment and supplies reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>															
<p>Environ Review</p> <input type="checkbox"/>	<p>Please note: Complete the Environment Review section only if the identified condition or circumstance contributed to the incident.</p>															
	<p>Review of environment (select all that apply):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Member's physical environment evaluated, and modified if necessary, for safety issues</td> </tr> <tr> <td><input type="checkbox"/> Member's physical environment evaluated, and modified if necessary, to increase accessibility</td> </tr> <tr> <td><input type="checkbox"/> Member's interpersonal relationships within their environment evaluated, and accommodated/modified if necessary, for safety reasons</td> </tr> <tr> <td><input type="checkbox"/> Other; describe _____</td> </tr> </table>	<input type="checkbox"/> Member's physical environment evaluated, and modified if necessary, for safety issues	<input type="checkbox"/> Member's physical environment evaluated, and modified if necessary, to increase accessibility	<input type="checkbox"/> Member's interpersonal relationships within their environment evaluated, and accommodated/modified if necessary, for safety reasons	<input type="checkbox"/> Other; describe _____											
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<input type="checkbox"/> Other; describe _____																
	<p><input type="checkbox"/> Resolution following environmental review. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Environment reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>															

Systemic Resolutions

<p>Systemic Resolution</p> <p><input type="checkbox"/></p>	<p>Please note: Completion of the Systemic Resolutions section is optional. If you chose to complete this section, please provide a brief summary with a detailed description of the changes and/or modifications made.</p> <p><input type="checkbox"/> Policy. Reviewed formal written policy or procedure governing the activity and modified as needed. Staff are able to reference agency guidelines or protocols.</p> <p><input type="checkbox"/> Consistent implementation of policy. Reviewed and modified, as necessary, to assure that verbal instructions are the same as procedural requirements. Policies and procedures are up to date.</p> <p><input type="checkbox"/> Adequate policy. Policies and procedures are complete, meet regulatory requirements, and are consistent with established standards and accepted practice expectations. Policies and procedures are clear and concise.</p> <p><input type="checkbox"/> Communication and awareness. There is adequate communication regarding new policy requirements. Staff and others are aware of changes or revisions to policy or procedure.</p> <p><input type="checkbox"/> Employee screening. There were adequate policy requirements for screening employees. Individuals with established histories of behavior that could compromise member safety/care (including abuse and neglect) are not working with members.</p> <p><input type="checkbox"/> Training. There are adequate policy requirements for training. Staff are required by policy to meet any minimum training requirements or demonstrate competencies.</p> <p><input type="checkbox"/> Fiscal control. There are adequate and consistent policy requirements for the management and control of member funds.</p> <p><input type="checkbox"/> Assessment. There are adequate policy requirements for proper assessment of member health, behavioral, and other critical support needs and preferences.</p> <p><input type="checkbox"/> Planning. There are adequate policy requirements for proper member planning and revision of supports based on changing needs.</p> <p><input type="checkbox"/> Monitoring. There are adequate policy requirements for monitoring services and supports to assure safety, meeting critical needs, and providing services in accordance with member plans and agency requirements.</p> <p><input type="checkbox"/> Documentation. There are adequate policy requirements for member records, including privacy, and documentation.</p> <p><input type="checkbox"/> Other, describe _____</p> <p><input type="checkbox"/> Resolution of systemic factor(s). Describe specifically how these reviews and/or assurances will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> No resolution required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p> <p>Detailed description:</p>
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Submission Instructions: If this is a completed investigation and an initial report was submitted please send final documentation and note that you are closing the case. The form may be submitted to the appropriate MCO shown below.

Amerigroup Iowa, Inc.

- Fax: 844-400-3465
- Provider Call Center: 1-800-454-3730
- Email: Aincidents@amerigroup.com

AmeriHealth Caritas Iowa, Inc.

- Fax: 844-341-7647 | Attn.: AmeriHealth Caritas Iowa, Urgent, Quality Department
- Provider Telephone Services: 1-844-411-0579
- Non-Provider Telephone Services: 1-855-332-2440
- TTY: 1-844-214-2471 | 24 hours a day, 7 days a week
- Email: ACIACriticalIncidentReporting@amerihealthcaritas.com

UnitedHealthcare Plan of the River Valley, Inc.

- Submit completed form by fax to 1-855-371-7638 or email to critical_incidents@uhc.com
- Provider Services Call Center: 1-888-650-3462

Iowa Medicaid Enterprise

- Habilitation and Integrated Health Home providers: email (preferred) to hcbsir@dhs.state.ia.us or (FAX) 515-725-3536
- HCBS Waiver Providers: submit via the Iowa Medicaid Provider Access (IMPA) system