

INCIDENT REPORT CONFIDENTIAL		Initial (Pending Investigation) <input type="checkbox"/> Completed (Investigation Completed) <input type="checkbox"/>		<input type="checkbox"/> Amerigroup Iowa <input type="checkbox"/> AmeriHealth Caritas <input type="checkbox"/> United Healthcare Community Plan					
INSTRUCTIONS Submit this form with as much information as possible within required reporting timeframes. If additional investigation is required for full resolution, when submitting the follow-up information please be sure to indicate the incident was previously reported to ensure a duplicate report is not created and the information is linked to the initial report. Do NOT make copies of this report. Attach additional pages if needed. Submit to member's MCO using the information on the back of this form.									
MEMBER (check which apply) HCBS Waiver <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Brain Injury <input type="checkbox"/> Elderly <input type="checkbox"/> Health & Disability <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Physical Disability <input type="checkbox"/> Children's Mental Health <input type="checkbox"/> State Plan: Habilitation <input type="checkbox"/> Grants: MFP		Last Name, First Name, Middle Initial			Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female	
		<input type="checkbox"/> Member <input type="checkbox"/> Visitor		Medicaid Member ID#					
		Street Address				Member Plan ID#			
		City, State, ZIP				Member/Visitor Phone Number			
DETAILS OF MAJOR INCIDENT <i>(Requires notification by end of the next day following incident; check which apply)</i> <input type="checkbox"/> Physical Injury Requiring Physician Treatment or Hospital Admission to or by Member <input type="checkbox"/> Death <input type="checkbox"/> Emergency Mental Health <input type="checkbox"/> Law Enforcement <i>(Non-Medical Involvement)</i> <input type="checkbox"/> Abuse <i>(Requires DHS Notification)</i> <input type="checkbox"/> Prescription Error <i>(Treatment Required)</i> <input type="checkbox"/> Location Unknown / Elopement Could this incident have been prevented? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Incident _____ Time of Incident _____			Were services being provided? <input type="checkbox"/> Yes <input type="checkbox"/> No			Case Manager notified? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, when?</i>	
		Date of Awareness/Discovery _____ Time of Awareness/Discovery _____			Does member care plan need modification? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		Location (Be specific and include facility name, street address, building number, floor)							
		Is additional information attached?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
		Clear and concise description of the incident. Include follow-up actions taken or follow-up actions planned. (Attach additional pages as needed)							
WITNESS(ES) <i>(Please provide relationship to member)</i>		Last Name, First Name, Middle Initial			Contact Information / Telephone Number				
		Last Name, First Name, Middle Initial			Contact Information / Telephone Number				
PROVIDER INFORMATION		Provider Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No				Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		National Provider Identification (NPI) Number:		Name of Provider / Facility:					
				Street Address:					
		Provider ID:		City, State, ZIP:					
				Summary of Provider's recommendation, if applicable.					
PERSON COMPLETING REPORT		Last Name, First Name, Middle Initial			Agency/Office Telephone Number			Guardian Notification <input type="checkbox"/> Yes Date _____ Time ____ <input type="checkbox"/> No <input type="checkbox"/> N/A	
		Signature and Title			Date	Time	DHS Notification <input type="checkbox"/> Yes Date _____ Time ____ <input type="checkbox"/> No <input type="checkbox"/> N/A		

[Back of Critical Incident Form]

Critical Incident Submission Guidelines

Per Iowa Administrative Code, chapter 77:

Major incidents require notification by the end of the next calendar day following the incident. Minor incidents are reported to staff's supervisor within 72 hours of the incident. Cases of Abuse require notification to the DHS Abuse Hotline (1-800-362-2178) and the member's MCO. *Note: Mandatory incident reporting requirements to other entities continue to apply, including but not limited to Iowa Code chapter 235B and Iowa Administrative Code chapter 50.*

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.

Amerigroup Iowa

- Fax: 844-400-3465
- Provider Call Center: 1-800-454-3730
- Web: https://providers.amerigroup.com/ProviderDocuments/IAIA_CriticalIncidentsReportingForm.pdf
- Email: IAincidents@amerigroup.com



AmeriHealth Caritas

- Fax: 844-341-7647 | Attn.: AmeriHealth Caritas Iowa, Urgent, Quality Department
- Provider Telephone Services: 1-844-411-0579
- Web: <http://www.amerhealthcaritasia.com/provider/manual-forms/index.aspx>
- 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 Community Plan

- 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
- Web: <http://www.uhccommunityplan.com/health-professionals/ia.html>
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