

INCIDENT REPORT

CONFIDENTIAL



INSTRUCTIONS: This Incident Report Form is used to report adverse incidents or injuries that occur to members. Complete this report in full and submit the original to the Risk Manager IMMEDIATELY after the incident. Do NOT make copies of this report. Fax the completed form to 1-813-283-5475 or email to .FL_incidents@wellcare.com.

PERSON INJURED	Last Name, First Name, Middle Initial		Date of Birth		<input type="radio"/> Male	<input type="radio"/> Female
	<input type="radio"/> Associate		<input type="radio"/> Visitor		<input type="radio"/> Member	
	Street Address			Member ID #		
	City, State, ZIP			Contact Number		
DETAILS OF INCIDENT	Date of Incident		Time of Incident			
	Admission Date		Time of Admission			
	Location (Be specific and include facility name, street address, building number, floor)					
	Diagnosis and Diagnosis Codes		Is additional information attached? <input type="radio"/> Yes <input type="radio"/> No			
	Clear and concise description of the incident. Include follow-up actions taken or follow-up actions planned.					
WITNESS(ES)	Last Name, First Name, Middle Initial		Street Address		City, State, ZIP	
	Last Name, First Name, Middle Initial		Street Address		City, State, ZIP	
PHYSICIAN INFORMATION	Physician notified? <input type="radio"/> Yes <input type="radio"/> No			Hospitalized? <input type="radio"/> Yes <input type="radio"/> No		
	If yes, complete the following:	Name of Physician/ Facility				
		Street Address				
		City, State, ZIP				
Summary of physician's recommendation, if applicable						
PERSON COMPLETING REPORT	Last Name, First Name, Middle Initial		Agency/Office		Telephone Number	
	Signature		Date	Time	Was AHCA notified? <input type="radio"/> Yes <input type="radio"/> No	
DO NOT WRITE BELOW THIS LINE						
HUMAN RESOURCES	Summary and Disposition					
	Last Name, First Name, Middle Initial		Title		Date	
RISK MANAGER	Last Name, First Name, Middle Initial		Title		Date	

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