Incident Report Form

Subscriber ___________________
Visitor ______________________
Employee ___________________

This report is to be completed for ALL injuries occurring within a facility.
Report is to be printed and submitted to Risk Management within 24 hours of occurrence.
Fax to: 1-800-873-5292

Name: ____ Facility Name:____

Subscriber #:____________________________ Subscriber D. O. B.____________________________________ O Male O Female

Address:____
(Street Number. Name. City. State, Zip)

Telephone #:____ Emergency Telephone #:____________________________

Incident Date:____ Incident Time:____________________________________

DESCRIBE INCIDENT (include WHO, WHAT, WHERE, HOW, WHY, ICD-9-CM Code injury elements):

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____
____

WITNESS (ES) (list persons directly involved):

Name	Position	Address	Phone #

Physician Notified? O Yes O No Time Notified:____________ By Whom?______________________

Physician Name:____Phone#:___________________________________

Address:____

Brief Statement of Treatment Given / Recommended by Physician:

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'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.