

# Incident Report



**C O N F I D E N T I A L**

**WellCare Health Plans, Inc.**  
The WellCare Group of Companies

**INSTRUCTIONS:** This Incident Report Form is used to report adverse incidents or injuries that occur to members, visitors, or associates. Complete this report in full and submit the original to HR immediately after the incident. Do NOT make copies of this report. Fax the completed report to **800-873-5292**.

<b>PERSON INJURED</b>	Last Name, First Middle Initial		Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
	<input type="checkbox"/> Associate		<input type="checkbox"/> Visitor		<input type="checkbox"/> Member			
	Street Address				Member ID #			
	City, State, Zip Code				Contact Number			
<b>DETAILS OF INCIDENT</b>	Date of Incident:			Time of Incident:				
	Location (Be specific and include facility name, street address, building number, floor, direction such as NE corner, etc.)							
	Diagnosis and diagnosis codes			Is additional information attached?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Clear and concise description of incident.							
<b>WITNESS(ES)</b>	Last Name, First Middle Initial		Street Address		City, State, Zip			
	Last Name, First Middle Initial		Street Address		City, State, Zip			
<b>PHYSICIAN INFORMATION</b>	Physician notified?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hospitalized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, complete the following:	Name of Physician or Facility						
		Street Address						
		City, State, Zip						
		Summary of physician's recommendation, if applicable.						
<b>PERSON COMPLETING REPORT</b>	Last Name, First Middle Initial			Department		Telephone Number		
	Signature			Date		Time		
<b>DO NOT WRITE BELOW THIS LINE</b>								
<b>HUMAN RESOURCES</b>	Summary and Disposition:							
	Last Name, First Middle Initial			Title		Date:		
<b>RISK MANAGER</b>	Last Name, First Middle Initial			Title		Date:		