Incident Report

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

WellCare®

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.**

PERSON INJURED	Last Name, First Middle Initial		Date of Birth		☐ Male	☐ Female
	☐ Associate	☐ Visitor			☐ Member	
	Street Address				Member ID #	
	City, State, Zip Code				Contact Number	
DETAILS OF INCIDENT	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?		☐ Yes	☐ No
	Clear and concise description of incident.					
WITNESS(ES)	Last Name, First Middle Initial		Street Address		City, State, Zip	
	Last Name, First Middle Initial		Street Address		City, State, Zip	
PHYSICIAN INFORMATION	Physician notified?	☐ Yes	☐ No	Hospitalized?	☐ Yes	☐ No
	If yes, complete the following:	Name of Physician or Facility				
		Street Address				
		City, State, Zip				
		Summary of physician's recommendation, if applicable.				
PERSON COMPLETING REPORT	Last Name, First Middle Initial			Department	Telephone Number	
	Signature			Date	Time	

DO NOT WRITE BELOW THIS LINE

HUMAN RESOURCES	Summary and Disposition:		
	Last Name, First Middle Initial	Title	Date:
RISK MANAGER	Last Name, First Middle Initial	Title	Date: