Provider Adverse Incident Form

AmeriHealth Caritas Florida

Instructions: The Provider Adverse Incident Form is used by providers to report adverse incidents or injuries that affect AmeriHealth Caritas Florida members. Providers must complete this report in full immediately when the incident occurs, and no later than within 48 hours of finding or being notified of the incident. Fax the completed form to AmeriHealth Caritas Florida's Risk Manager at **1-305-436-7485** or email **acflriskmanagement@amerihealthcaritasfl.com.**

Do not make copies of this report.

Provider information

Name of Provider or Facility:		
Address:	Date of report:	
City:	State:	ZIP:
Phone number:	Email:	

Member information

Name of health plan member:			
Address:			
City:	State:	ZIP:	
Member ID:	Date of birth:	Age:	Sex:

Details of incident

Date of incident:	Time of incident:	Date of admission:
Diagnosis and diagnosis codes:		

Location of incident:

- ☐ Doctor office
- ☐ Hospital or patient room
- ☐ Emergency room
- ☐ Intensive care unit (ICU)
- ☐ Operating room
- ☐ Home health
- ☐ Recovery room
- ☐ Other:

Type of adverse occurrence:

- ☐ Death
- ☐ Brain damage
- ☐ Fracture or dislocation of bones or joints
- ☐ Transfer of member to a more acute level of care due to an incident
- ☐ Surgical repair of damage, not listed in the informed consent
- ☐ Surgical procedure performed on incorrect site
- ☐ Medication errors and adverse reaction to medication
- ☐ Loss of neurological, physical, or sensory function
- ☐ Permanent disfigurement
- ☐ Retained foreign bodies
- ☐ Surgical procedure performed in relation to an incident
- ☐ Incorrect surgical procedure performed
- ☐ Surgical procedure performed on incorrect patient
- ☐ Other (specify):

List name and license numbers of personnel, and the capacity in which they were involved with the incident (e.g., attending physician, surgeon, or emergency room physician). For unlicensed personnel, list their level of involvement.
List the license numbers of witnesses. For unlicensed personnel, list their level of involvement.
Summarize the incident. Be as precise and detailed as possible.
Describe corrective and proactive actions taken to prevent recurrence of such incidents. Use additional sheets for complete response.
Indicate whether or not a physician was called and, if so, provide a brief statement of the physician's recommendation for medical treatment, if any.

Name:	Title:	
Signature:	Date:	Time: