



HEALTH CHOICE®

Leading the Way to Quality Care

Provider Adverse Incident Form

Instructions: The Provider Adverse Incident Form is used by providers to report adverse incidents or injuries that affect Prestige Health Choice 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 Prestige Health Choice's Risk Manager at **1-305-436-7485** or email phcriskmanagement@prestigehealthchoice.com.

Do not make copies of this report.

Provider Information

Name of Provider or Facility:		
Address:	Date of Report:	
City:	State:	ZIP Code:
Phone Number:	Email:	

Member Information

Name of Health Plan Member:			
Address:			
City:	State:	ZIP Code:	
Member ID:	Date of Birth:	Age:	Sex:

Details of Incident

Date of Incident:	Time of Incident:	Date of Admission:
Diagnosis & Diagnosis Codes:		
Location of Incident:		
<input type="checkbox"/> Doctor Office	<input type="checkbox"/> Intensive Care Unit (ICU)	<input type="checkbox"/> Recovery Room
<input type="checkbox"/> Hospital or Patient Room	<input type="checkbox"/> Operating Room	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Home Health	

Details of Incident (continued)

Type of Adverse Occurrence:

- | | |
|--|--|
| <input type="checkbox"/> Death | <input type="checkbox"/> Loss of Neurological, Physical, or Sensory Function |
| <input type="checkbox"/> Brain Damage | <input type="checkbox"/> Permanent Disfigurement |
| <input type="checkbox"/> Fracture or Dislocation of Bones or Joints | <input type="checkbox"/> Retained Foreign Bodies |
| <input type="checkbox"/> Transfer of Member to a More Acute Level of Care Due to an Incident | <input type="checkbox"/> Surgical Procedure Performed in Relation to an Incident |
| <input type="checkbox"/> Surgical Repair of Damage, Not Listed in the Informed Consent | <input type="checkbox"/> Incorrect Surgical Procedure Performed |
| <input type="checkbox"/> Surgical Procedure Performed on Incorrect Site | <input type="checkbox"/> Surgical Procedure Performed on Incorrect Patient |
| <input type="checkbox"/> Medication Errors and Adverse Reaction to Medication | <input type="checkbox"/> 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.

Person Completing the Report

Name:	Title:	
Signature:	Date:	Time: