



# Aetna Better Health<sup>®</sup> of Florida

## Provider Critical/Adverse Incident Reporting Form

In accordance with reporting requirements as mandated and regulated by the Agency for Healthcare Administration (AHCA) SMMC (Medicaid contract), please submit the completed, typed form to the Aetna Better Health of Florida Risk Manager **immediately** via fax at **1-877-479-8564**.

For assistance in completing the incident report form, contact our Risk Manager at **954-858-3246**.

### I. Provider/Facility Information

Provider/Facility Name	NPI	Phone	Email
Street Address	City	Zip Code	County
Name of Person Submitting Report	Title	Phone	Email

### II. Patient Information

Patient Name	Age/DOB	Aetna/Medicaid ID Number	
Street Address	City	Zip Code	County
Aetna Better Health Healthcare Line of Business (please click the appropriate box)			
<input type="checkbox"/> Medicaid (MMA) <input type="checkbox"/> Long Term Care (LTC) <input type="checkbox"/> Comprehensive (MMA&LTC) <input type="checkbox"/> Florida Healthy Kids (FHK)			

### III. Incident Information

Incident Type – Please check the appropriate box
<input type="checkbox"/> Death by homicide, suicide, abuse, neglect, or exploitation
<input type="checkbox"/> Death as a result of a healthcare provider or is otherwise unexpected
<input type="checkbox"/> Injury or illness as a result of a healthcare provider and which is otherwise unexpected
<input type="checkbox"/> Brain damage, spinal damage, permanent disfigurement, fracture/dislocation of bones/joints
<input type="checkbox"/> Any condition that is not consistent with the patient’s pre-existing physical condition and results an extended length of stay, transfer to a higher level of care, or the need for definitive and specialized medical attention or surgical intervention.
<input type="checkbox"/> Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.
<input type="checkbox"/> Suspected abuse, neglect, or exploitation
<input type="checkbox"/> Sexual battery
<input type="checkbox"/> Medication errors
<input type="checkbox"/> Suicide attempts
<input type="checkbox"/> Altercations requiring medical intervention
<input type="checkbox"/> Elopement
<input type="checkbox"/> Other (see incident description)

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**Incident Description**

**Please provide a narrative of the incident, including but not limited to the patient's pre- and post-incident condition, patient's family/support, outcome of incident, and further action planned by the provider/facility. Be brief, but include important information, including who, what, where, when, and how of the event/situation.**

**Patient's Medical Diagnoses/Past Medical History**

**Patient's Prescription and OTC Medications**

**Report any pertinent ACTION taken in response to the occurrence**

**IV. Witness Information**

<b>Witness Name</b>	<b>Phone</b>	<b>Fax</b>	<b>Email</b>
<b>Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>County</b>

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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