GOLD KIDNEY HEALTH PLAN

Provider Critical/Adverse Incident Reporting Form

In accordance with reporting requirements as mandated and regulated by the Agency for Healthcare Administration (AHCA) please submit the completed, typed form to the Gold Kidney Health Plan Risk Manager **immediately** via fax at 866-580-0122

For assistance in completing the incident report form, contact our Risk Manager at **813-847-5561**

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	Gold Kidney Health Plan ID Number	
Street Address	**City**	**Zip Code**	**County**

III. Incident Information

Incident Type – Please check the appropriate box
☐ Death by homicide, suicide, abuse, neglect, or exploitation
☐ Death as a result of a healthcare provider or is otherwise unexpected
☐ Injury or illness as a result of a healthcare provider and which is otherwise unexpected
☐ Brain damage, spinal damage, permanent disfigurement, fracture/dislocation of bones/joints
☐ 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.
☐ Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.
☐ Suspected abuse, neglect, or exploitation
☐ Sexual battery
☐ Medication errors
☐ Suicide attempts
☐ Altercations requiring medical intervention
☐ Elopement
☐ Other (see incident description)

Incident Description
Please provide a clear and concise description of the facts of the incident including time, date, exact location, and any coding elements needed for the annual report based on ICD-10-CM.
Please describe any injuries sustained;
Please indicate whether or not a physician was called and, if so, a brief statement of the physician's recommendations for medical treatment, if any.
Please list all persons known to be involved in the incident, including witnesses, along with locating information for each. • You should consider adding a few more boxes like the one that already appears in IV Witness Information.

IV. Witness Information

Witness Name	Phone	Fax	Email
Street Address	**City**	**Zip Code**	**County**

Signature: _____ **Date:** _____