

Provider Critical/Adverse Incident Reporting Form

In accordance with reporting requirements as mandated and regulated by the Agency for Health Care 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 **844-294-6535**.

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 ID Number
Street Address	City	Zip Code

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 in 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 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.

[Empty text box for incident description]

Please describe any injuries sustained.

[Empty text box for 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.

[Empty text box for physician recommendations]

Please list all persons known to be involved in the incident, including witnesses, along with locating information for each.

[Empty text box for persons involved]

IV. Witness Information

Witness Name	Phone	Fax	Email
Street Address	City	Zip Code	County

Signature: _____

Date: _____

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