**Critical Incident Report Form** 

**Please complete and submit this form to UnitedHealthcare Community Plan of Nebraska:**

**Submit this form by:**

* Email — **critical\_incidents@uhc.com**
* Fax — **855-371-7638**

If you need assistance completing the form, please contact your provider advocate or email us at critical\_incidents@uhc.com. Thank you.

# Member’s name:

**Member’s UnitedHealthcare Community Plan ID number:**

**Member’s address:**

**Member Medicaid ID Number:**

**Member’s date of birth:**

# Choose the type of incident (choose one):

[ ]  Suicide attempt

[ ]  Suicide death

[ ]  Non-suicide death

[ ]  Unexpected death

[ ]  Homicide

[ ]  Homicide attempt

[ ]  Allegation of abuse/neglect (physical)

[ ]  Allegation of abuse (psychological)

[ ]  Fire setting or property damage

[ ]  Medication error resulting in requiring medical intervention

[ ]  Adverse drug reaction

[ ]  Unauthorized leave

[ ]  Accidental injury with significant medical intervention

[ ]  Emergency medical treatment resulting from injury, medication error, or adverse medication reaction

[ ]  Use of restraints or seclusion requiring significant medical intervention

[ ]  Unusual, unexpected illness or disease

[ ]  Other serious occurrence, including sexual contact between peers or peers and staff which member is under treatment

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| **Describe the incident (attach another sheet if necessary) including the Who, What, When, Where, Why and How. Just state the facts. DO NOT INCLUDE OPINION.** |
| **Describe any actions taken as a result of incident.** |
| **Who caused the incident (if applicable)?** |  |
| **Name of the person who first became aware of the incident and their relationship to the member:**  |
| **Where did the incident occur (choose one)?**[ ] Family [ ] School[ ] Group home or assisted living facility [ ] Place of employment[ ] Medical facility [ ] Other (please describe):[ ] Nursing facility |
| **Incident date:** | **Incident time:** |
| **Was the incident reported to local emergency authorities, licensing agency, Case Manager, Police/Sheriff, Parent, Other?** [ ] Yes. When? [ ] No |
|  |
| **Your name:** |  |
| **Your relationship to the member:** |  |
| **Your or your agency’s tax identification number:** |
| **Your or your agency’s email address:** |  |
| **Which best describes you or your agency?**[ ] Long Term Services and Support (LTSS) (please describe below)[ ] Primary care provider[ ] Specialty provider (please describe below)[ ] Other (please describe below) |