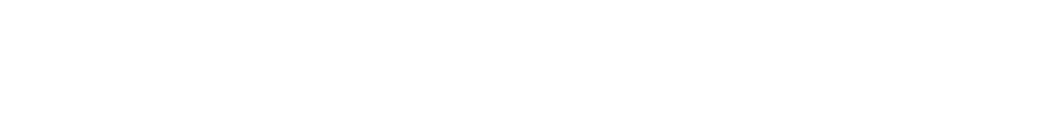
**Critical Incident Report Form** A close up of a sign

Description automatically generated

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



**Submit this form by:**

* Email — [**critical\_incidents@uhc.com**](mailto: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.](mailto:critical_incidents@uhc.com.%20) 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

|  |  |
| --- | --- |
| **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) | |