

Critical incident report form

UnitedHealthcare Community Plan of Missouri



Please complete and submit this form in one of the following ways:

- Email: critical_incidents@uhc.com
- Fax: 855-371-7638

If you need help 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's Medicaid ID number:

Member's date of birth:

Choose the type of incident (choose one):

- | | |
|------------------------|---|
| Death | Use of seclusion/restraints |
| Suicide | Absence from a mental health facility without permission (AWOL) |
| Attempted suicide | Medication errors |
| Homicide | Adverse medication reactions |
| Attempted homicide | Quality of care concerns |
| Physical abuse/neglect | Significant accidental injury |
| Sexual abuse/neglect | |
| Verbal abuse/neglect | |
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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** **If yes, when?** **No**

Your name:

Your relationship to the member:

Your or your agency's tax ID number (TIN):

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)