Please type information, print, and send via secure email.

Adverse Incident Report for All LOC

Including: FFS Provider Type 73 and 74

Member name: ______________________ MassHealth ID: ______________________

Health Plans: ☐ MBHP ☐ Tufts ☐ HNE ☐ Fallon ☐ WellSense ☐ AHP ☐ FFS ☐ OTHER

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other ______________ DOB: __________ Age: ______

Date and time of incident: mm/dd/yyyy ______________________________

Date and time of discovery: mm/dd/yyyy ______________________________

Plan Incident Code for Member: ______________________

Facility: ____________________ City: ________________ Provider number: ____________

☐ 24-hour facility ☐ Non-24-hour facility

Level of care: ________________ Diagnosis: ______________________________

Type of incident: ______________________________

State agency involvement: ☐ DMH ☐ DCF ☐ DYS ☐ DPPC ☐ DDS ☐ Other

Restraints used?

☐ None ☐ Mechanical ☐ Chemical ☐ Physical ☐ Multiple ☐ Seclusion: ____________________

Describe incident. If AWA, please include search, notification, and commitment status:

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Describe immediate response to the incident:

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Please check if recommended:

☐ Internal investigation ☐ Policy and procedure review ☐ Staff training ☐ Disciplinary action to staff

☐ Please check if additional information is attached.

Person reporting (and title): ______________________ Telephone #: ________________

Signature: ______________________________ Date: ____________________

Please submit to Carelon Behavioral Health within 24 hours of incident via secure email to Ombuds@carelon.com or fax to 877-335-5452.

Date Revised: 03/08/2024