Aetna Better Health® of Florida

Provider Critical/Adverse Incident Reporting Form

In accordance with reporting requirements as mandated and regulated by the Agency for Healthcare Administration (AHCA) SMMC (Medicaid contract), please complete the form and submit **immediately** to the Aetna Better Health of Florida Provider Engagement **mailbox** at **FLProviderEngagement@aetna.com** (**subject line of email: Critical/Adverse Incident Report**). For assistance in completing the incident report form or any questions contact us at MMA: **1-800-441-5501**, LTC: **1-844-645-7371**, FHK: **1-844-528-5815.**

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	Aetna/Medicaid ID Number	
Street Address	**City**	**Zip Code**	**County**
Aetna Better Health Healthcare Line of Business (please click the appropriate box)			
☐Medicaid (MMA) ☐Long Term Care (LTC) ☐Comprehensive (MMA&LTC) ☐Florida Healthy Kids (FHK)			

III. Incident Information

Incident Type – Please check the appropriate box
☐ Death by homicide, suicide, abuse, neglect, or exploitation
☐ Death as a result of a healthcare provider or is otherwise unexpected
☐ Injury or illness as a result of a healthcare provider and which is otherwise unexpected
☐ Brain damage, spinal damage, permanent disfigurement, fracture/dislocation of bones/joints
☐ Any condition that is not consistent with the patient's pre-existing physical condition and results an extended length of stay, transfer to a higher level of care, or the need for definitive and specialized medical attention or surgical intervention.
☐ Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.
☐ Suspected abuse, neglect, or exploitation
☐ Sexual battery
☐ Medication errors
☐ Suicide attempts
☐ Altercations requiring medical intervention
☐ Elopement
☐ Other (see incident description)

Incident Description
Please provide a narrative of the incident, including but not limited to the patient's pre- and post-incident condition, patient's family/support, outcome of incident, and further action planned by the provider/facility. Be brief, but include important information, including who, what, where, when, and how of the event/situation.
Patient's Medical Diagnoses/Past Medical History
Patient's Prescription and OTC Medications
Report any pertinent ACTION taken in response to the occurrence

IV. Witness Information

Witness Name	Phone	Fax	Email
Street Address	**City**	**Zip Code**	**County**

Signature: _____ **Date:** _____

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