Healthy Louisiana
Adverse Incident Reporting Form

The provider **must** fax this form to the appropriate health plan of the member addressed below **within 24 hours** of the incident.

ABH: 1-860-262-9174 **ACLA: 1-844-341-7641** **HB: 1-855-859-5044** **LHCC: 1-866-704-3063** **UHC: 1-877-554-3362**

Member Name:	Diagnosis:
Member Number:	Provider Level of care:
Member Date of Birth:	Incident Location:
Gender:	Date and Time of Incident:
Legal Status:	Date Form Completed:

Select any of the following categories that were involved.

	Death		Abuse		Seclusion
	Attempted Suicide		Neglect		Restraint (Physical, Mechanical, Protective Hold, Chemical)
	Significant Medication Error		Extortion		Other: (Please explain)
	Need for Emergency Services		Exploitation		
	Elopement		Significant Injury/Illness		

Description of Event: (including specifics on incident, using as many pages as necessary, numbering, dating, and signing each)

Action taken to ensure safety of all involved: (including debriefing efforts and steps to avoid similar future events)

Select the appropriate boxes that apply.

	Parent/Guardian notified?		Date/Person notified:
	Law enforcement/Protective services notified (if applicable)?		If yes, agency and contact information:
	Member seen by psychiatrist, physician or nurse after incident?		If yes, treatment:

Signature: ____

Print Name: ____

Phone number: ____

Email Address: ____

Provider Name: ____

Date: ____

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