blue california | Promise Health Plan

Critical Incident Reporting Line: (888) 210-2705

Critical Incident Report Form		
Member Name:	**Contact Number:**	
Member ID:	**LOB:**	Is member receiving: ☐ CBAS ☐ IHSS ☐ NF ☐ MSSP
Date of Incident:	**Time of Incident:**	☐ AM/PM ☐
Location of Incident (Include Address)**:**		
Name of Person Completing Form:		
Position/Occupation:	**Contact Number:**	
Names of Health Plan/IPA Employees or Volunteers Involved in Incident:	**Contact Numbers:**	
1.		
2.		
3.		
Names of Additional Parties Involved:	**Contact Numbers:**	
1.		
2.		
3.		
4.		
Description of Incident and Background (Include all relevant circumstances leading up to the incident, whether the incident was witnessed, etc.)**:**		

Who Else was Informed of the Incident – Include Names (e.g. APS, DCFS, Ombudsman, County Mental Health Services, Police, Fire Department, family members, etc.)**:**
Actions Taken to Date (Include details like date and time, names, contact numbers and specific supports/referrals provided, and member's response.)**:**
Follow Up Actions Planned:

COMPLETED FORM SHOULD BE <u>FAXED</u> TO: (323) 889-2109

Critical Incident Report Form Reviewed By:

_____ Date: _____/_____/_____
(Signature of Employee)

_____ Date: _____/_____/_____
(Signature of Manager)