INCIDENT REPORT
CONFIDENTIAL

WellCare Health Plans

INSTRUCTIONS: This Incident Report Form is used to report adverse incidents or injuries that occur to members. Complete this report in full and submit the original to the Risk Manager IMMEDIATELY after the incident. Do NOT make copies of this report. Fax the completed form to 1-813-283-5475 or email to .FL_incidents@wellcare.com.

PERSON INJURED	Last Name, First Name, Middle Initial	Date of Birth	☐ Male	☐ Female
	☐ Associate	☐ Visitor	☐ Member	
	Street Address	Member ID #		
	City, State, ZIP	Contact Number		
DETAILS OF INCIDENT	Date of Incident	Time of Incident		
	Admission Date	Time of Admission		
	Location (Be specific and include facility name, street address, building number, floor)			
	Diagnosis and Diagnosis Codes	Is additional information attached? ☐ Yes ☐ No		
	Clear and concise description of the incident. Include follow-up actions taken or follow-up actions planned.			
WITNESS(ES)	Last Name, First Name, Middle Initial	Street Address	City, State, ZIP	
	Last Name, First Name, Middle Initial	Street Address	City, State, ZIP	
PHYSICIAN INFORMATION	Physician notified? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No		
	If yes, complete the following:	Name of Physician/ Facility		
		Street Address		
		City, State, ZIP		
		Summary of physician's recommendation, if applicable		
PERSON COMPLETING REPORT	Last Name, First Name, Middle Initial	Agency/Office	Telephone Number	
	Signature	Date	Time	Was AHCA notified? ☐ Yes ☐ No
DO NOT WRITE BELOW THIS LINE				
HUMAN RESOURCES	Summary and Disposition			
	Last Name, First Name, Middle Initial	Title	Date	
RISK MANAGER	Last Name, First Name, Middle Initial	Title	Date	

66829