Healthy Louisiana
Adverse Incident Reporting Form

The provider **must** fax this form or any form with the necessary information to the appropriate health plan of the member addressed below **within 1 business day** of discovery of the incident.

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

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

Select any of the following categories that were involved.

	Abuse		Seclusion
	Neglect		Restraint (Physical, Mechanical, Protective Hold, Chemical)
	Extortion		Death
	Exploitation		

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: _____