Incident Report Form

WellCare

Subscriber _____

Visitor _____

Employee _____

This report is to be completed for ALL injuries occurring within a facility.
Report is to be printed and submitted to Risk Management within 24 hours of occurrence.
Fax to: 1-800-873-5292

Name: _____ Facility Name:_____

Subscriber #:_____ Subscriber D. O. B._____ O Male O Female

Address:_____

(Street Number. Name. City. State, Zip)

Telephone #:_____ Emergency Telephone #:_____

Incident Date:_____ Incident Time:_____

DESCRIBE INCIDENT (include WHO, WHAT, WHERE, HOW, WHY, ICD-9-CM Code injury elements):

_____

_____

_____

_____

WITNESS (ES) (list persons directly involved):

Name	Position	Address	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Notified? O Yes O No Time Notified:_____ By Whom?_____

Physician Name:_____Phone#:_____

Address:_____

Brief Statement of Treatment Given / Recommended by Physician:

_____

_____

_____

_____