Incident Report

C O N F I D E N T I A L

WellCare

WellCare Health Plans, Inc.
The WellCare Group of Companies

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 813-283-5475 or email to FL_incidents@wellcare.com.

PERSON INJURED	Last Name, First Middle Initial	Date of Birth	☐ Male	☐ Female
	☐ Associate	☐ Visitor	☐ Member	
	Street Address		Member ID #	
	City, State, Zip Code		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, direction such as NE corner, etc.)			
	Diagnosis and diagnosis codes	Is additional information attached?	☐ Yes	☐ No
	Clear and concise description of incident. Include follow up actions taken or follow up actions planned.			

WITNESS(ES)	Last Name, First Middle Initial	Street Address	City, State, Zip
	Last Name, First Middle Initial	Street Address	City, State, Zip

PHYSICIAN INFORMATION	Physician notified?	☐ Yes	☐ No	Hospitalized?	☐ Yes	☐ No
	If yes, complete the following:	Name of Physician or Facility				
		Street Address				
		City, State, Zip				
		Summary of physician's recommendation, if applicable.				

PERSON COMPLETING REPORT	Last Name, First 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 Middle Initial	Title	Date:
RISK MANAGER	Last Name, First Middle Initial	Title	Date: