

**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.

**ACL: 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.

<input type="checkbox"/> Abuse	<input type="checkbox"/> Seclusion
<input type="checkbox"/> Neglect	<input type="checkbox"/> Restraint (Physical, Mechanical, Protective Hold, Chemical)
<input type="checkbox"/> Extortion	<input type="checkbox"/> Death
<input type="checkbox"/> 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.

<input type="checkbox"/>	Parent/Guardian notified	<input type="checkbox"/>	Date/Person notified:
<input type="checkbox"/>	Law enforcement/Protective services notified (if applicable)	<input type="checkbox"/>	If yes, agency and contact information:
<input type="checkbox"/>	Member seen by psychiatrist, physician or nurse after incident	<input type="checkbox"/>	If yes, treatment:

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_