Nevada Medicaid Critical Incident Report

Date: ____________

Instructions:
Submit all pages of this form with as much information as possible within the required reporting timeframes.

Submit form to **critical_incident@silversummithealthplan.com**

Types of Potential Critical Incidents (check all that apply)

- Major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs at a facility licensed by the State to provide publicly funded Behavioral Health Services
- An unexpected death of a member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services
- Abuse, neglect, exploitation or unexpected death of a Member (not to include child abuse)
- Any event involving a member that has attracted or is likely to attract media attention
- Unauthorized leave of mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions

Provider/Facility Information

National Provider Identifier (NPI) Phone

Provider or Agency Name

Provider Address

City State Zip Code

Reporting Party

Reporter's First Name Last Name

Title

Email Address Phone Number

Point of contact to discuss incident if different from reporter:

First Name Last Name Phone Number

Nevada Medicaid Critical Incident Report

Medicaid Member

Medicaid ID Number First Name Last Name

Address

City State Zip Code

Date of Birth Age Member's Gender Male Female Other

Incident

Date Incident Occurred (required) Date Incident Discovered (required)

Description of Incident:

Location of Incident

Select Location Type (If other, specify)

Member's Residence	Community	Other Location
Living alone	Work	State Facility
Living with relative	School	Correctional Facility or Jail
Living with unrelated person	Vehicle	Nursing Facility
Residential Care Facility	Day Program	Hospital or Clinic
Assisted Living		PMIC
Other	Other	Other

Name of Location or Facility

Location or Facility Address

City State Zip Code

Involved Persons/Witness

Persons involved during incident Provide names, relationships (if other, specify), names and title of facility personnel

Staff Family Roomate Other

Staff Family Roomate Other

Staff Family Roomate Other

Staff Family Roomate Other

Staff Family Roomate Other

Member Location

Member's whereabouts at the time of the report if known:

Member's Residence Jail Hospital Unknown If unknown, actions planned to locate member: