

Incident Form

Wisconsin | Anthem Blue Cross and Blue Shield | Family Care program

Preparer information	
Your first name:	Your last name:
Your role/title:	
Your phone number:	Your email address:
Member information	
Member first name:	Member last name:
Member Medicaid ID:	Member date of birth:
Member living arrangement:	
Other living arrangement:	
Incident information	
Select first incident type:	
Select second incident type (if applicable):	
Select third incident type (if applicable):	
What date did the incident occur?	
What date did you become aware of the incident?	
Where did the incident occur?	
If other, where did the incident occur?	
Did this incident affect other members?	
If yes, explain the effect on other members:	

Please provide a summary of the incident:

What actions were taken immediately to reduce or mitigate harm?

Incident type

Please complete additional information based on the incident type(s) selected above.

All incident types

Did the member obtain medical evaluation and treatment?

Severity of injury/illness to the member:

What was the nature of the illness/injury to the member?

Was the member hospitalized?

Did the incident require admission to an institute for mental disease?

Did the member change residence as a result of the incident?

Missing person	
Is/was the member missing for 24 hours or more?	
Is the member still missing?	
Date the member was located:	
Does the member live in a residential facility?	
Is the member under guardianship/protective placement?	
Does the member have a significant medical condition that would deteriorate without medication and care?	
Is the area experiencing potentially life-threatening weather conditions?	
Does the member present a safety threat to themselves?	
Does the member present a safety threat to others?	
Medication error(s)	
What kind of medication error?	
Was the member's prescribing physician notified?	
Emergency use of restrictive measures	
What type of restrictive measure was used?	
Unapproved use of restrictive measures	
What type of restrictive measure was used?	
Have you submitted an application for the use of restrictive measures for this member?	
If no, when do you anticipate submitting the application for the use of restrictive measures?	
Involved parties	
Date member or member's legal decision maker was informed of the incident (if applicable):	
Name of provider organization(s) Involved:	
Other entity(s) notified (for example, APS, Law Enforcement):	
If yes, indicate which entity(s):	

Prevention and remediation

What preventive strategies were in place at the time of the incident?

What preventive measures are you keeping or putting in place to prevent this incident from happening again?

What was the root cause(s) of the incident?

How is the incident being remediated?

Uploads

Please upload any other relevant documents.

Please submit the completed form to WI_Incidents@anthem.com.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled in your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.