TENNCARE BEHAVIORAL HEALTH ADVERSE OCCURRENCE REPORT

Provider Name:	**Consumer Name:** **(Last, First)**
Name of Reporting Person:	**Address:**
Name/Title of Person Submitting Report:	**SSN:**
Contact Number:	**DOB:**
Date Reported:	**Date of Incident:**
	MCO: ☐ **UHCCP** ☐ **Wellpoint** ☐ **BlueCare** ☐ **TennCare Select**

Persons Involved (Check all that apply) ☐ **Clients** ☐ **Staff** ☐ **Persons Not Associated with Facility** ☐ **Other** _____	**Location of Incident** ☐ **Residential** _____ ☐ **Inpatient**_____ ☐ **Crisis Stabilization Unit (CSU)** _____ ☐ **Supported Housing** _____

Type of Behavioral Health Adverse Occurrence (Check One) ☐ **Suicide Death** ☐ **Non-Suicide Death** ☐ **Death-Cause Unknown** ☐ **Homicide** ☐ **Homicide Attempt w/significant medical intervention*** ☐ **Suicide Attempt w/significant medical intervention***	☐ **Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)** ☐ **Accidental Injury w/significant medical intervention*** ☐ **Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention*** ☐ **Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention*** ***Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay**
Summary of Adverse Occurrence: **(Be specific, precise and as detailed as possible)**	

Revised: April 2024

Summary of Action Taken by Facility/Provider:

- ☐ **Notified 911**
- ☐ **Taken to Physician**
- ☐ **Taken to Hospital**
- ☐ **Notified Fire Department**
- ☐ **Notified Police**
- ☐ **Notified Mental Health Case Manager**
- ☐ **Notified Parents or Next of Kin**
- ☐ **Staff Debriefing/Training**
- ☐ **Reported to DHS _____(Date)**
- ☐ **Reported to DCS _____(Date)**
- ☐ **Other**

(Specify)_____

_____

MCO USE ONLY

Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)
UHCCP has received notification of this AO and will follow up with provider as appropriate. UHCCP will work with provider surrounding any issues identified.

FAX TO: UnitedHealthcare Community Plan 1-888-785-1434 Wellpoint 1-877-423-9976 BlueCare/TCS 1-866-259-0203