



BlueCareSM
TennCareSelect

Home Health Critical Incident Form

Email completed forms to BlueCareQOC@bcbst.com. If email isn't available, fax completed forms to **1-855-339-3022**.

Home Health Agency Information

Home Health Agency Involved: _____

Home Health Agency Address

Street Address: _____

City: _____ State: ____ ZIP: _____

Phone Number: _____

Home Health Service Type and Amount Provided:

BlueCross Provider Number: _____

Reference Number: _____

Diagnosis Code: _____

Member Information

Member's Full Name: _____

Region:

- East West CHOICES
 Middle TennCare*Select* CoverKids

Member ID: _____

Member SSN: ____ - ____ - ____ Member DOB: ____ / ____ / ____

Member Address

Street Address: _____

City: _____ State: ____ ZIP: _____

Incident Information

Incident Occurrence Date: ____ / ____ / ____

Incident Location (Please check all that apply):

- Home—Inside Day Program/
Work/School Community —
Unsupervised
 Home—Outside Community —
Supervised Unknown
 Vehicle

Incident Address (if different than member address)

Street Address: _____

City: _____ State: _____ ZIP: _____

Type of Incident (Please check all that apply):

- Unexpected Death
- Suspected Sexual Abuse
- Safety Issue
- Financial Exploitation
- Suspected Physical Abuse
- Suspected Neglect
- Life Threatening Medical Emergency
- Theft
- Suspected Mental Abuse
- Major Severe Injury
- Medication Error

Nature of Incident (Brief description, 2-3 sentences):

Incident Required Home Health Agency Action (Please check all that apply):

- Hospital ER
- X-ray (to rule out fracture)
- CPR
- Abdominal Thrust (Heimlich)
- Manual Restraint
- Mechanical Restraint
- Hospitalization—Medical
- Taken to Physician
- MH Mobile Crisis Team
- Emergency Psychotropic Medication
- Hospitalization—Psychiatric
- Reported to APS
- Police
- Protective Equipment
- Reported to CPS
- 911 Call
- Incarceration
- Notified Family Member

Typing your name below signifies your e-signature.

Agency Staff Member

Name: _____

Phone: _____ Date: ____ / ____ / 20 ____

Agency Reviewing Supervisor

Name: _____

Phone: _____ Date: ____ / ____ / 20 ____