Behavioral Health ADVERSE OCCURRENCE REPORT
BlueCross BlueShield of Tennessee

Facility/Provider Name:	Member Name:
Information of Person submitting report:	Member ID:
Name:	Member SSN:
Title:	Member Address:
Phone:	DOB:
Email:	Member's Health Plan:
Date Submitted to BCBST:	☐ Medicare Advantage ☐ BCBST ☐ Other:

Date Submitted to BCBST: _____

Persons Involved (Check all that apply)

- ☐ Clients
- ☐ Staff
- ☐ Persons Not Associated with Facility
- ☐ Other: _____

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Member's Related Current Level of Care (LOC), check one:

- ☐ Inpatient Acute Care
- ☐ Inpatient Sub-acute Care
- ☐ Residential Treatment (RTC)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Crisis Stabilization Unit (CSU)
- ☐ Outpatient Services (please specify): _____

Type of Behavioral Health Adverse Occurrence (Check One)

- ☐ Suicide Death
- ☐ Non-Suicide Death, cause known
- ☐ Death-Cause Unknown
- ☐ Homicide, resulting in fatality
- ☐ 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*
- ☐ Self-injurious behavior 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)

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) _____

INSTRUCTIONS: Please fax completed form to BCBST, BH Clinical Risk Management Dept. at: **1-866-259-0203** within 24 business hours of notification of occurrence.