Coordinated Care of Washington, Inc.

External Critical Incident Notification Form 2024

***Required Field**

Member Information

***Member Name (Last, First, MI)**

***Member DOB**

***Provider One Number**

Incident Information

***Date of Incident** ***Date of Discovery**

Facility (BH facility, FQHC, or independent health Provider if applicable; provide brief description and all individuals involved)

***Staff Reporter (Name, title, facility, contact number)**

***Member has documented Behavioral Health diagnosis**

***Type of Incident**

***Location of Incident**

***Facility (Provide a brief description and all individuals involved)**

***Description of Incident (Limit 750 characters)**

***Disposition**

- In Jail
- Inpatient
- Inpatient Psychiatric
- Inpatient SUD
- Discharged Home
- Unknown at the time of this submission
- Other

***Notification (Select all that initiated)**

- Police
- CPS/APS
- DOH (outbreak/exposure events)
- DCYFS
- Family Notified
- Medicaid Control Fraud Unit
- Aging and Long-Term Support Administration (Residential Care Services)
- Other

Attestation

*The submitter attests that the information being submitted has been verified as true and accurate.

***Document completed/submitted by (Name, title, facility, and date)**

Submit this form to:

CI Inbox: WA_QOCCI_REPORTING@CENTENE.COM

CI Fax: 866-270-1885