*For instructions to submit or examples of PQOCs or, see page 2.*

A. Reporting Provider

|  |  |
| --- | --- |
| **Date** Click or tap to enter a date. | **Time** Click or tap here to enter text. |
| **Name** Click or tap here to enter text. | **Facility** *(if applicable)*Click or tap here to enter text. |
| **Phone #** Click or tap here to enter text. |

B. Member Information

|  |  |
| --- | --- |
| **Last Name** Click or tap here to enter text. | **First Name** Click or tap here to enter text. |
| **ID** Click or tap here to enter text. | **DOB** Click or tap to enter a date. |
| **Health Plan** Click or tap here to enter text. | **Sex** Click or tap here to enter text. |
| **Line of Business** Click or tap here to enter text. | **Diagnosis** *(if known)* Click or tap here to enter text. |

C. Treating Provider Information *(Complete Facility and/or Practitioner, as applicable)*

|  |  |
| --- | --- |
| **Facility Name** Click or tap here to enter text. | **Facility Beacon ID or NPI** *(if known)*Click or tap here to enter text. |
| **Practitioner Name** Click or tap here to enter text. | **Provider Beacon ID or NPI** *(if known)* Click or tap here to enter text. |
| **Address** Click or tap here to enter text. | **Phone #** Click or tap here to enter text. |

D. Incident Information

|  |  |
| --- | --- |
| **Date** Click or tap to enter a date. | **Time** Click or tap here to enter text. |
| **Mental Health Level of Care** *(if other, note in the description section)* Choose an item. | **Substance Use Level of Care** *(if other, note in description)* Choose an item. |
| **Description of the Incident** Click or tap here to enter text. |
| **Steps Taken by the Provider or Beacon to Ensure the Safety of the Member** Click or tap here to enter text. |

**Instructions to Submit**

* Referrals for PQOCs should be sent to the appropriate quality team immediately and within 24 hours of a PQOC concern involving members (unless otherwise noted in the provider manual).
* Fax the form to the fax number below, based on the Region/State associated with the health plan *(Note: No need to fax Instructions to Submit or Examples of PQOCs sections)*:

|  |  |  |
| --- | --- | --- |
| **Region/ Division** | **State of the Health Plan** | **Fax** |
| Northeast 1 | MA (Non-Medicaid), ME, RI, VT**Note: This form is not applicable to MassHealth (Medicaid) or NH.** Please follow local notification process. | General: 781-994-7642 |
| Northeast 2 | DC, DE, MD, NJ, NY **Note: This form is not applicable to CT or PA.** Please follow local notification processes. | General except Emblem/GHI, VNSNY, CT, and PA:855-610-5011Emblem/GHI and VNSNY only: 855-677-7672 |
| Southeast/ Central | AL, CO, FL, IA, IL, IN, KS, KY, LA, MI, MN, MO, MS, NC, ND, NE, OH, OK, SC, SD, TN, TX, VA, WI, WV **Note: This form is not applicable to AR or GA.** Please follow local notification processes. | General (CO, TX, OK, KY, IL, MI): 888-643-4197FL: 305-722-3027 KS: 785-338-9020 |
| West | AK, AZ, CA, HI, ID, MT, NM, NV, OR, UT, WA, WY**Note: This form is not applicable to WA.** Please follow local notification processes. | General (CA & HI): 877-635-4602 |
| Employer | Employer health plan for any state | 877-635-4602 |

**Examples of Potential Quality of Care (PQOC) Concerns** *(May vary by client/state)*

* Death or injury (not suicide)
* Death (suicide) or attempted suicide
* Self-injurious behaviors
* Physical assault, sexual behavior or assault
* Accident or overdose
* Medication or treatment errors
* Falls
* Death due to natural causes, expected or unexpected
* Inappropriate use of restraint, seclusion, or restrictions
* Elopement, abduction, or leaving against medical advice (AMA)
* Concerns regarding clinical practice
* Concerns regarding attitude or service
* Provider unprofessional or inappropriate behavior
* Lack of discharge planning or coordination of care
* Failure to have or follow standards of care, including disaster management protocols and staff misconduct