Optum

Please fax completed forms to Optum at **844-814-5698**

Mass General Brigham Health Plan– MassHealth Daily Adverse Incident Report

Notifications: DMH ____ DCF ____ DYS ____ DPPC ____ DDS ____ Other ____

Client: _____ **Medicaid RID #**: _____

M ____ **F** ____ **DOB**: _____ **Age**: _____

Facility: _____ **Unit**: _____ **City**: _____

24-hour facility: ____ **Non-24-hour facility:** ____

Date and Time of Incident:

_____

Date and Time of Discovery:

_____

Type of Incident:

_____

Describe Incident. If AWA, please include search, notification and commitment status:

_____

_____

_____

_____

_____

Describe Immediate Response to the Incident:

_____

_____

_____

_____

_____

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ **Time in Restraints**: _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure

Review_____ Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting: _____ **Telephone #**: _____

Title: _____

Signature: _____**Date:** _____