sunshine health

Enable editing and enable content for macros or the form will not work properly.

Provider Event Notification Form

Instructions: Complete this form in full. Email form to: **SUN_PQOC@CENTENE.COM or Fax to: 1-844-940-0686.** Include all the facts available after becoming aware of the member situation or outcome and send to Risk Management as soon as possible.

Do **NOT** make copies of this form or attach to the member medical record
Remember to report all cases of suspected abuse, neglect or exploitation to APS/DCF: 1-800-96A-BUSE or
https://www.myflfamilies.com/service-programs/abuse-hotline/frequently-asked-questions.shtml

Member's Information

☐ **First Name:** ______________________ ☐ **Last Name:** ______________________
☐ **ID #:** ______________________ ☐ **Member DOB:** ______________________
☐ **AHCA Region:** ______________________ ☐ **Age:** ______________________
☐ **Health Plan:** ______________________ ☐ **Member Gender:** ______________________

Event Information

☐ **Date Event Occurred:** ______________________ ☐ **Date Reported to Plan:** ______________________
☐ **Location of Event:** ______________________ ☐ **Time Reported to Plan:** ______________________
☐ **Address of Event:** ______________________
☐ **Treatment Provided:** ______________________ **If other, enter here:** ______________________
☐ **Type of Event:** ______________________
☐ **If other:** ______________________
☐ **Location (at time of event):** ______________________
☐ **Description/Summary of Event (include specific details, any injury, outcome, hospitalization, ER visit, and name of hospital):** ______________________
☐ **Name of witness/witnesses if present & known:** ______________________
☐ **Follow Up (already completed and/or planned, interventions):** ______________________

Provider Information

☐ **Provider Name:** ______________________ ☐ **Provider NPI:** ______________________
☐ **PCP Contact:** ______________________ ☐ **Group NPI:** ______________________
☐ **Group Name:** ______________________
☐ **For Home Health Services:** ______________________
☐ **Name of Licensed Staff Involved:** ______________________

Referral Source Information

☐ **Form Completed By:** ______________________ ☐ **Date Completed:** ______________________
☐ **Contact Number:** ______________________ ☐ **Time Completed:** ______________________

Hospitalization

☐ **Hospital:** ________________________________

☐ **Admit Date:** ___________________________

☐ **City:** ____________________________________

☐ **Discharge Date:** ________________________

☐ **ICD 10 Diagnosis:** __________________________

APS/DCF/Other Reporting

☐ **Notified as appropriate:** __________________________

If other, enter here: ___________________________

☐ **Was Case Accepted?** ______________________________

☐ **Agent ID #:** ___________________________

☐ **Case ID #:** ____

Submittal Instructions

1. Sunshine Health MMA, LTC Non-HCBS related, Child Welfare, SMI, FLCMS, Ambetter and Wellcare member events, once the form is completed:
    a. Click the submit button below to automatically send the form to Risk Management, or

       Submit to Risk Management

    b. Email the completed form to SUN_PQOC@centene.com.

Questions

➢ **Monday – Friday 7:30 a.m. to 4:45 p.m. (Eastern)**

Sun_PQOC@centene.com

If urgent contact: 1-844-667-4623 Quality/Risk Management

For Quality Only

☐ **Date Received:** ___________________________

☐ **Meets PQOC Criteria:** _________________________

☐ **Time Received:** ___________________________

☐ **Form Reviewed By:** ____

☐ **Additional Notes** (if needed):