

Critical Incident Reporting Form for Members

Please fax this form to the Care Coordination Department at 312-946-3899
or call our Critical Incident Hotline with this information at 855-653-8127.

For help to translate or understand this letter, or request in alternative formats, Call Member Services at 1-877-723-7702 (TTY: 711). We are available seven (7) days a week. Our call center is open Monday-Friday 8:00 a.m. – 8:00 p.m. Central time. On weekends and Federal holidays, voice messaging is available. If you leave a voice message, a Member Services representative will return your call no later than the next business day. The call is free.

*Member Name (Last, First):	Member Medicaid Number:
*DOB:	Member BCBS ID Number:
Primary Care Provider (PCP):	*Plan Type: <input type="checkbox"/> MMAI (Medicare Medicaid Alignment Initiative) SM
*Categories of Eligibility:	
<input type="checkbox"/> Elderly	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Physical Disabilities	<input type="checkbox"/> Supportive Living Facilities
<input type="checkbox"/> Nursing Facility Services	<input type="checkbox"/> Assisted Living Program
	<input type="checkbox"/> HIV/AIDS
	<input type="checkbox"/> Aged, Blind Disabled
	<input type="checkbox"/> None of the above
*Referral Source (person or entity who is reporting the incident):	
Name: _____	
_____	Relationship to Member:
_____	Phone: _____
*Indicate the Date and Time of Incident. Date: _____ Time: _____	
*Location of Incident:	
<input type="checkbox"/> Member's Home	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Acute Inpatient	<input type="checkbox"/> Outpatient Facility
<input type="checkbox"/> Residential Treatment Facility	<input type="checkbox"/> Emergency Room
	<input type="checkbox"/> TFC
	<input type="checkbox"/> Shelter Care
	<input type="checkbox"/> Day Treatment
	<input type="checkbox"/> Other
Address: _____	
_____	Phone: _____
*Summary of Incident: (May use additional pages, if needed)	
Name of all Individuals involved in Critical Incident: _____	
Name of Agency involved in Critical Incident, if applicable: _____	
*Suspected Abuse, Neglect or Exploitation critical incidents are required to be reported to the following State Agencies. <u>Please check the box to indicate which agency was notified.</u>	

⇒*Indicate the date and time of notification. Date: _____ Time: _____

- For members age 18 and older: Illinois Department on Aging-Adult Protective Services Hotline Phone: 866-800-1409 (voice) TTY: 888-206-1327
- For members in Nursing Facilities: Department of Public Health Nursing Home Complaint Hotline Phone: 800-252-4343
- For members in Supportive Living Facilities: Department of Healthcare and Family Services SLF Complaint Hotline Phone: 800-226-0768
- Law Enforcement: 9-1-1 to reach the local law enforcement agency

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Critical Incident Reporting Form for Members, continued

Critical Incidents involving Fraud to the Medicaid System are required to be reported to the following:

- Illinois Office of the Inspector General Phone: 800-368-1463
- BCBS Special Investigations Fraud Abuse Hotline Phone: 800-543-0867

***Required information; field must be completed**

*Type of Incident		
<input type="checkbox"/> Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional / Verbal Abuse	<input type="checkbox"/> Neglect <input type="checkbox"/> Passive Neglect <input type="checkbox"/> Active / Wilful Neglect <input type="checkbox"/> Self-Neglect	<input type="checkbox"/> Exploitation <input type="checkbox"/> Misappropriation of property including theft of member property <input type="checkbox"/> Financial <input type="checkbox"/> Sexual Exploitation <input type="checkbox"/> Other
<input type="checkbox"/> Medical/Psychiatric <input type="checkbox"/> Medical / Psychiatric Emergency <input type="checkbox"/> Self-inflicted Injury/Wound requiring medical attention	<input type="checkbox"/> Behavioral Issues <input type="checkbox"/> Member is missing <input type="checkbox"/> Member is in possession of a weapon <input type="checkbox"/> Member displays physically aggressive behavior <input type="checkbox"/> Suicide attempt by member <input type="checkbox"/> Suicide ideation / threat by member <input type="checkbox"/> Suspected alcohol or substance abuse by member <input type="checkbox"/> Property damage by member of \$50 or more <input type="checkbox"/> Self-abuse	<input type="checkbox"/> Nursing Home <input type="checkbox"/> Any crime that occurs on facility property <input type="checkbox"/> Loss of electrical power in excess of an hour <input type="checkbox"/> Evacuation of residents for any reason <input type="checkbox"/> Physical injury to residents from a mechanical failure or force of nature <input type="checkbox"/> Fire alarm activation with injuries or damage to the apartment
<input type="checkbox"/> Environmental Hazards <input type="checkbox"/> Fire / Natural Disaster damaged or affected <input type="checkbox"/> Other <input type="checkbox"/> None		<input type="checkbox"/> Criminal Act / Law Enforcement <input type="checkbox"/> Member arrested, charged with or convicted of a crime <input type="checkbox"/> Provider arrested, charged with or convicted of a crime <input type="checkbox"/> Placement into a correctional facility <input type="checkbox"/> Fraudulent activities by member <input type="checkbox"/> Fraudulent activities on the part of the provider <input type="checkbox"/> Fraudulent activities of caregiver, ex. timesheet signed for hours not worked
<input type="checkbox"/> Deaths <input type="checkbox"/> Expected deaths <input type="checkbox"/> Unexpected deaths <input type="checkbox"/> Unusual death of member <input type="checkbox"/> Death related to abuse, neglect or exploitation <input type="checkbox"/> Death, other party	<input type="checkbox"/> Sexual Misconduct <input type="checkbox"/> Sexual harassment <input type="checkbox"/> Sexually problematic behavior	
<input type="checkbox"/> Caregiver <input type="checkbox"/> Robbery / burglary on premises <input type="checkbox"/> Hazardous / physical condition discovered <input type="checkbox"/> Serious incident resulting in legal action		
*Name and phone number of individual completing form if different than referral source listed above:		
Name:		Phone:
*Date form completed:		

***Required information; field must be completed.**

Blue Cross Community MMAI (Medicare-Medicaid Plan)SM is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC's plan depends on contract renewal.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, a Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-723-7702 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-723-7702 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-723-7702 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-723-7702 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-723-7702 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-723-7702 (TTY :711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-723-7702 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelpfen. Unsere Dolmetscher erreichen Sie unter 1-877-723-7702 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-723-7702 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-723-7702 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية لإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-723-7702. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपलब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, बस हमें 1-877-723-7702 (TTY: 711) पर फोन करें. कोई व्यक्ति जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-723-7702 (TTY: 711). Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-723-7702 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-723-7702 (TTY :711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-723-7702 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-723-7702 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。