SERIOUS REPORTABLE EVENTS IDENTIFICATION FORM

Member Name: _____

Member #:_____ **Date of Birth:** _____

Date(s) of Service: _____ **Event Date:** _____

Facility Name: _____ **Facility Type:** _____

Medica Provider #:_____ **Date Reported:** _____

Reported by: _____ **Phone:** _____

Indicate the type of event and the event description as defined in the Medica Serious Reportable Events policy:

☐**Surgical/Invasive Procedure** ☐**Product or Device** ☐**Patient Protection**

☐**Care Management** ☐**Environmental** ☐ **Criminal**

☐**Radiologic**

Serious Reportable Event: (*Example: Surgery performed on wrong body part)*

Description/Details of Event:

Please send this form via confidential fax to:
952-992-2389
ATTN: PIA

Or mail it to:
Medica
ATTN: PIA, Mail Route CP415
PO Box 9310
Minneapolis, MN 55440-9310