



## 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

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