TENNCARE BEHAVIORAL HEALTH ADVERSE OCCURRENCE REPORT

Provider Name:	**Consumer Name:** **(Last, First)**
Name of Reporting Person:	**Address:**
Name/Title of Person Submitting Report:	**SSN:**
Contact Number:	**DOB:**
Date Reported:	**Date of Incident:**
	MCO: ☐ **UHCCP** ☐ **Wellpoint** ☐ **BlueCare** ☐ **TennCare Select**

Persons Involved (Check all that apply) ☐ **Clients** ☐ **Staff** ☐ **Persons Not Associated with Facility** ☐ **Other** _____	**Location of Incident** ☐ **Residential** _____ ☐ **Inpatient**_____ ☐ **Crisis Stabilization Unit (CSU)** _____ ☐ **Supported Housing** _____

Type of Behavioral Health Adverse Occurrence (Check One) ☐ **Suicide Death** ☐ **Non-Suicide Death** ☐ **Death-Cause Unknown** ☐ **Homicide** ☐ **Homicide Attempt w/significant medical intervention*** ☐ **Suicide Attempt w/significant medical intervention***	☐ **Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)** ☐ **Accidental Injury w/significant medical intervention*** ☐ **Self-injurious behavior w/significant medical intervention*** ☐ **Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention*** ☐ **Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention*** ***Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay**

Summary of Adverse Occurrence: **(Be specific, precise and as detailed as possible)**

Revised: September 2025

Summary of Action Taken by Facility/Provider:

- ☐ **Notified 911**
- ☐ **Taken to Physician**
- ☐ **Taken to Hospital**
- ☐ **Notified Fire Department**
- ☐ **Notified Police**
- ☐ **Notified Mental Health Case Manager**
- ☐ **Notified Parents or Next of Kin**
- ☐ **Staff Debriefing/Training**
- ☐ **Reported to DHS _____(Date)**
- ☐ **Reported to DCS _____(Date)**
- ☐ **Other**

(Specify)_____

_____

MCO USE ONLY

Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)

FAX TO: UnitedHealthcare Community Plan 1-888-785-1434 Wellpoint 1-877-423-9976 BlueCare/TCS 1-866-259-0203