

# Critical incident report form

Please complete and submit this form to UnitedHealthcare Community Plan when you:

- Report abuse, neglect or exploitation of a UnitedHealthcare Community Plan member to the Texas Department of Family and Protective Services (DFPS)
- Become aware of a critical incident, including abuse, neglect or exploitation, related to a UnitedHealthcare Community Plan member

This notification should **not** take the place of reporting to DFPS at 800-252-5400 or [TXAbuseHotline.org](https://www.txabusehotline.org). For more information, please view our [Critical Incident Reporting: Including Abuse, Neglect and Exploitation training](#).



**Submit this form by:**

**Email:** [critical\\_incidents@uhc.com](mailto:critical_incidents@uhc.com) | **Fax:** 855-371-7638

If you need assistance completing the form, please contact your provider advocate or email us at [critical\\_incidents@uhc.com](mailto:critical_incidents@uhc.com).

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

City:

State:

ZIP code:

Member's date of birth:

**Member's UnitedHealthcare Community Plan benefit plan (choose one):**

Children's Health Insurance Program (CHIP)

UnitedHealthcare Dual Complete®

STAR

Special Needs Plan

STAR+PLUS

STAR Kids

Unknown

**Is the member on a waiver (choose one)?**    Yes    No    Unknown

**Service area where the member lives (choose one):**

Bexar

Medicaid Rural Service Area Northeast

Dallas

Nueces

Jefferson

Tarrant

Harris

Travis

Hidalgo

Unknown

Medicaid Rural Service Area Central



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**Choose the type of incident (choose one):**

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Abuse	Serious injury that resulted in medical intervention or hospitalization
Neglect	Criminal victimization
Exploitation	Death
Unauthorized use of restraint, seclusion or restrictive interventions	Other (please describe)

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**Describe the incident (attach another sheet if necessary):**

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**Describe any actions taken as a result of incident:**

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**Who caused the incident (if applicable)?**

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**Name of the person who first became aware of the incident and their relationship to the member:**

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**Where did the incident occur (choose one)?**

Family home	School
Group home or assisted living facility	Place of employment
Medical facility	Other (please describe):
Nursing facility	

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**Incident date:**

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**Incident time:**

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**Was the incident reported to local emergency authorities?**      Yes. When?      No

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**Was the incident reported to the Texas Department of Family and Protective Services?**

(Required for any abuse, neglect or exploitation incidents)

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Yes. When?

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DFPS incident number:

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No

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**Your name:**

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**Your relationship to the member:**

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**Your or your agency's tax ID number:**

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**Your or your agency's email address:**

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**Which best describes you or your agency?**

Long-term services and supports (LTSS) (please describe):

Primary care provider

Specialty provider (please describe):

Other (please describe):

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**Date you completed this form:**

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## Questions?

Connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#). For additional contact information, visit our [Contact us](#) page.