argus dental vision
a premier benefits organization

I. REPORTING PROVIDER

Name of Reporting Provider	Address
City / Zip	County / Telephone
Person Reporting	Title

II. PATIENT INFORMATION

Patient Name	DOB / Sex / ❑ Medicaid / ❑ Medicare
Patient Identification Number	Telephone Number
Patient Address	Original Diagnosis
City / Zip / County	ICD-9 Code for Original Diagnosis

III. HOSPITALIZATION

Name of Facility of Campus	Address
City / Zip / County	Telephone
Person Reporting	Title
Admission Date / Time	Diagnosis

IV. INCIDENT INFORMATION

Date of Incident: ______________________

Location of Incident (address):____

Facility Unit:

- ❑ Emergency Room
- ❑ Operating Room
- ❑ Recovery Room
- ❑ Outpatient Services
- ❑ Radiology
- ❑ Patient Room
- ❑ CCU
- ❑ Blood Bank
- ❑ Laboratory
- ❑ ICU
- ❑ Facility Campus
- ❑ Other: ____________________________

Other Health Care Provider:

- ❑ Assisted Living Facility
- ❑ Ambulatory Surgical Center
- ❑ Nursing Home
- ❑ Home Health
- ❑ Doctor's Office
- ❑ Name of Other Provider: ____________________________________

Was a physician called? ☐ Yes ☐ No

If a physician was called, please provide a brief statement of said physician's recommendations as to medical treatment (if any).

____

____

Note: If the incident involved a death, was the Medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No
Name and contact number of the Medical Examiner: _________________________________

IV.a. Describe (narrative) specific circumstances of the incident (including any physical findings). Include "Who", "What", "When (include date and time)", "Where", "How", and "Why" (use additional sheets as necessary for complete response):

____

____

____

IV.b. ICD-9-CM Codes

____________________________	_____________________	______________________
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

IV.c. List any equipment used, if directly involved in the incident (use additional sheets as necessary for complete response):

____

____

IV.d. Outcome of Incident (please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong site.
- ☐ Surgical procedure performed on the wrong patient.
- ☐ Wrong surgical procedure performed.
- ☐ Surgical procedure unrelated to the patient's diagnosis.
- ☐ Surgical repair of injuries from a planned surgical procedure.
- ☐ Surgical procedure to remove foreign objects remaining from a surgical procedure.
- ☐ Other: ____

____

IV.e. List persons involved and the capacity in which they were directly involved with this incident (i.e., ER physician, attending physician, surgeon, etc.):

____

____

IV.f. List witnesses and the capacity in which they were directly/indirectly involved (including location of witness(es):

____

V. ___________________________________ ____

Printed Name of Reporting Person Title Date

____

Signature of Reporting Person

Time Report Completed: _______________________

If an incident occurs in your office while caring for an Argus Dental & Vision Inc. member, please contact our Customer Service Department at 877-864-0625 option 1 and fax this completed form to 813-400-1782.