Coordinated Care of Washington, Inc.
External Critical Incident Notification Form 2025

***Required Field**

Member Information

***Member Name** (Last, First, MI)

***Member DOB Click or tap to enter a date.**

***Provider One Number**

Incident Information

***Date of Incident Click or tap to enter a date.**

***Date of Discovery Click or tap to enter a date**.

Facility (BH facility, FQHC, or independent health Provider if applicable; provide brief description and all individuals involved)

***Staff Reporter** (Name, title, facility, contact number)

***Member has documented Behavioral Health diagnosis** Choose an item.

***Type of Incident** Choose an item.

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***Location of Incident Choose an item.** Choose an item.

***Facility (Provide a brief description and all individuals involved)**

***Description of Incident (Limit 750 characters) Click or tap here to enter text.**

*Disposition

☐In Jail

☐Inpatient

☐Inpatient Psychiatric

☐Inpatient SUD

☐Discharged Home

☐Unknown at the time of this submission

☐Other

*Notification (Select all that initiated)

☐Police

☐CPS/APS

☐DOH (outbreak/exposure events)

☐DCYFS

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☐Family Notified

☐Medicaid Control Fraud Unit

☐Aging and Long-Term Support Administration (Residential Care Services)

☐Other Click or tap here to enter text.

Attestation

☐***The submitter attests that the information being submitted has been verified as true and accurate.**

***Document completed/submitted by (Name, title, facility, and date**)

Submit this form to:

CI Inbox: WA_QOCCI_REPORTING@CENTENE.COM

CI Fax: 866-270-1885