|  |  |
| --- | --- |
| [Company Name] [Street Address][City, State ZIP Code][Telephone][Fax][Web Address] |  |

 Fax Cover

|  |  |  |  |
| --- | --- | --- | --- |
| To: | MCO CONTACT | Fax: | MCO FAX NUMBER |
| From: | INSERT NAME | Date: | 7/25/2018 3:20:25 PM |
| Re: | **CHRIS Critical Incident Report Fax Cover** | Pages: | Number of Pages |
| Cc: |       |  |  |

**Additional Required Information:**

**Medicaid # (if not identified in CHRIS):** Medicaid #

**Time Incident Report Completed:** Insert time

**Incident Category:** Choose an item.

**Location of Incident:** Insert Facility Name/Address of Incident if known

**Provider Type:** Choose an item.

**Source for Critical Incident Data:**

 [ ]  Individual [ ]  Family/Caregiver [ ]  Provider [ ]  MCO Team

 [ ]  Anonymous [ ]  APS/CPS [ ]  DBHDS/State Agency [ ]  Ombudsman
 [ ]  Other

**Contact name and phone #:** Insert name and #

**Contact E-Mail:** Email address