|  |  |
| --- | --- |
| [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