MCO Subcontractor Liability Notification

|  |  |  |
| --- | --- | --- |
| **MCO Name:** | **Date Reported to DMAS:**  | **Subcontractor Name:** |
| **Reported by: Telephone Number:**  |
| **Date/Time of Incident: Member Name/Medicaid ID:**  |

**I. Description of the incident(s):**

**II. Was the subcontractor doing something other than required duties at time of accident? If yes, please explain.**

**III. Witnesses:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Company** **Address** | **Telephone** **Number** | **Incident Statement** |
|  |  |  |  **🞎 Yes 🞎 No** |
|  |  |  |  **🞎 Yes 🞎 No** |
|  |  |  |  **🞎 Yes 🞎 No** |

**IV. Was 911 and/or police/fire/rescue dispatched? If yes, please explain.**

**V. What is being done to prevent incidence reoccurrence?**

**VI. MCO CERTIFICATION**

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MCO Signature and Title: Date

**VII. DEPARTMENT REVIEWED/RECEIVED:**

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Department Signature and Title: Date