



# Serious Adverse Event Reporting Form

Serious adverse events involving Molina Healthcare of Florida, Inc.'s Specialty Plan Enrollees (Child Welfare, Severe Mental Illness, HIV/AIDS) must be reported to the health plan **immediately**.

Download and fill out this form. All fields are required.

Submit the completed form via email to [MFLSAEreporting@molinahealthcare.com](mailto:MFLSAEreporting@molinahealthcare.com)

<b>Health Plan Name:</b>	Molina Healthcare of Florida
<b>Specialty Product: SMI, CW, HIV</b>	
<b>Today's Date (MM/DD/YYYY):</b>	
<b>Area/Region:</b>	Region I
<b>County:</b>	
<b>SERIOUS ADVERSE EVENT</b>	
<b>Enrollee 10-Digit Medicaid ID#:</b>	
<b>Enrollee Full Name:</b> (Last, First)	
<b>Enrollee Date of Birth:</b> (MM/DD/YYYY)	
<b>Date of Event:</b>	
<b>Location of Event:</b> (address, provider name, phone number)	
<b>Serious Adverse Event Type:</b> <ul style="list-style-type: none"><li>• Suicide.</li><li>• Victim of Homicide.</li><li>• Baker Act of an enrollee aged twenty-one (21) years or younger.</li><li>• Death of an enrollee within one year of delivery or pregnancy termination.</li><li>• Death of an enrollee within one (1) year of life.</li><li>• Victim of abuse, neglect, or exploitation as defined by Section 415.102, F.S.</li><li>• Sexual battery or altercation requiring medical intervention.</li><li>• Resident elopement for enrollees in assisted care communities, as defined by Section 429.41, F.S.</li></ul>	

<p><b>Details of Event:</b>  [Include enrollee's age, sex, current medication (if applicable), source of information, all reported details about the event and any relevant factors leading up to the event, action taken by plan or provider, and any other pertinent information, including current status of enrollee].</p>	<p><b>Member History:</b> Member is a XX year old (Male/Female) with history most notable for</p>
<p><b>Follow-up planned or required:</b>  (Include information related to any plan or provider protocol that applies to the event)</p>	
<p><b>Staff Involved:</b>  (Name, title, e-mail, phone number of Staff involved and capacity in which they were directly involved)</p>	
<p><b>Witnesses:</b>  [Names, title (if applicable), e-mail, phone number of witnesses]</p>	
<p><b>Date Reported to Plan:</b></p>	
<p><b>Report submitted by:</b>  [Name, title (if applicable), e-mail address, phone number]</p>	
<p><b>Date Resolved:</b>  (Only if it has been resolved. If not resolved, indicate by stating "Pending." If pending, include the details in the current status and follow-up fields).</p>	