Foundational Community Supports (FCS)
Critical Incident or Death Notification Form

Washington | Medicaid

Submitter information	
Name:	Phone number:
Title:	Email:
Enrollee information	
Name:	FCS TPA ID:
DOB:	ProviderOne ID:
Critical incident information	
Date and time reported:	Date and time of incident or death:
Type of incident:	Location:

Brief description of incident

Comments (including follow-up actions taken)

To be completed by submitter:

☐ The information provided is complete and true.

☐ I expect to add additional information regarding actions taken in response to this incident.

☐ I am reporting the death of an enrollee that is not a critical incident.

Please note: This form is intended to inform *only* FCS of a critical incident or death.

Send this completed form to Wellpoint FCS team at FCSTPA@wellpoint.com.