Potential Member Safety Concern (PMSC) Reporting Form

(Completed forms should be faxed to the Appeals and Grievances Department at 717.541.6915)

A. PMSC report submitted by:

Capital Blue Cross staff:

Full name: Phone number:

Department: Date/Time of report:

Capital Blue Cross provider:

Full name:

Phone number: Date/Time of report:

Capital Blue Cross vendor:

Full name: Organization:

Phone number: Date/Time of report:

B. Member information:

Full name: DOB:

Member ID number: Sex:

Line of business/product:

C. Treating provider/facility/vendor information:

Provider/facility/vendor name:

Provider/facility/vendor address:

Provider/facility/vendor phone number:

Provider/facility Capital ID:

Point of contact at provider/facility/vendor (if available):

D. Date and time of the PMSC:

Date: Time:

E. Location/level of care the member was receiving at the time of the PMSC (e.g., inpatient, outpatient, home, partial hospitalization program, etc.):

Location/level of care:

F. Full description of the PMSC, including any actions that have been taken to ensure the safety of the member, if applicable:

Description:

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