4191 East Commerce Way
Sacramento, CA 95834

# Transfer/Termination Incident Report

*Required Field

| Member information | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First name: | | MI: | Last name: | | | Date of birth: | | Medi-Cal ID*: | |
| | | | | | | | | | |
| SSN#: | | | Phone number: | | | | | | |
| Mailing address: | | | | | | | | | |
| City: | | | State | | Zip code: | | | | |

| Physician information | | | | | | | |
|---|---|---|---|---|---|---|---|
| PPG/IPA name: | | PG/IPA # | | Counselor: | | Date: | |

| Incident report dates/type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1st Incident date: | | Level | ☐ | A | ☐ | B | ☐ | C |
| 2nd Incident date: | | Level | ☐ | A | ☐ | B | ☐ | C |
| 3rd Incident date: | | Level | ☐ | A | ☐ | B | ☐ | C |

| Description of incidents |
|---|
| |
| Date of letter to member following counseling session: _____<br>Attach copy of letter (recommend letter be sent by registered mail, return receipt request). |
| Documentation of counseling of patient regarding incident. (if counseling documented in the medical record by physician, PA, RNP attach copy of documentation): |

| For California Health & Wellness plan use only | | | |
|---|---|---|---|
| Date report received from PMG:<br>*witness report required | | Date of warning letter to member: | |
| Comments: | | | |