

MEDICAID SECOND OPINION FORM

Transaction Number

Prior Authorization Number

--

--

SECTION 1 TO BE COMPLETED BY PHYSICIAN RENDERING FIRST OPINION

Recipient's Name		Medicaid ID No.:	
Surgical Procedure Discussed and Recommended			
Pertinent History and Physical Findings			
Physician's Name and Office Address		Medicaid Provider Number	
		Specialty Code	
Appointment Date:	*Personal Signature of Physician Rendering First Opinion	Date:	

SECTION II TO BE COMPLETED BY PHYSICIAN RENDERING SECOND OPINION

Need for Surgery(Check One)	State Remarks:		
Confirmed			
Not Confirmed			
Surgical Procedure Recommended, if surgery confirmed:			
Appointment Date:	*Personal Signature of Physician Rendering Second Opinion	Date:	

SECTION III TO BE COMPLETED BY PHYSICIAN RENDERING THIRD OPINION

Need for Surgery(Check One)	State Remarks:		
Confirmed			
Not Confirmed			
Surgical Procedure Recommended, if surgery confirmed:			
Appointment Date:	*Personal Signature of Physician Rendering Third Opinion	Date:	

Upon completion of Section 1, the physician or the IHCP member must send this form to the second opinion physician with the patient's H&P lab results and x-rays, and so forth. A third opinion is covered only if the second opinion was not a recommendation for surgery. This form must be returned to the physician performing the surgery.

*Signature and the accompanying data must be in the original handwriting of the physicians.