To:
HMOs and Other Managed Care Programs
VIPs and Subscribers
Physicians and Physician Clinics
Physician Assistants
Independent Laboratories
Rural Health Clinics

Second Opinion Elective Surgery Request/Physician Report Form revised

The Second Opinion Elective Surgery Request/Physician Report Form published in the Medicine and Surgery section of the Physician Services Handbook is incorrect. The signature and date lines are missing. Please use the attached revised form for further requests.

The Wisconsin Medicaid and BadgerCare Update is the first source of program policy and billing information for providers.

Although the Update refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.
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Appendix 27
Second Opinion Elective Surgery Request/Physician Report Form
(for photocopying)

Recommending Surgeon Information

Date: _________ Note: The recommending surgeon must complete this side of the form before sending to the second opinion physician.

Check One:
☐ Would like the second opinion physician to send this form back to me.
☐ Would like the second opinion physician to send this form directly to the Medicaid fiscal agent.

Recipient (Patient) Information:
Name: _________________________________________ Medicaid ID Number: ______________________________
Address: _______________________________________ County: _________________________________________
______________________________________________ Telephone: _______________________________________
______________________________________________ Date of Birth: ______/_____/______ Sex: _____________

Recommending Surgeon (mailing address):
Name: _________________________________________ Provider Number: _________________________________
Address: _______________________________________ Telephone: _________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

If someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion, please specify:
Person to Contact: _______________________________ Telephone: _________________________________
Address: ________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Primary/Referring Physician (if different from above):
Name: _______________________________ Address: ________________________________________________

Check Proposed Procedure:

☐ Cataract extraction and/or intraocular lens implant (check if bilateral___): 66840, 66850, 66852, 66920, 66983, 66984
☐ Cholecystectomy: 47600, 47605, 47610, 56340, 56341, 56342

☐ D & C (diagnostic): 58120
☐ Hemorrhoidectomy: 46250, 46255, 46257, 46258, 46260, 46261, 46262

☐ Hernia repair (inguinal, age 5 or older) (check if bilateral___): 49505, 49520, 59525, 56316, 56317
☐ Hysterectomy: 56308, 58150, 58152, 58180, 58260, 58262, 58263, 58270, 58275, 58280

☐ Joint replacement – Hip (check if bilateral___): 27130, 27132
☐ Joint replacement – Knee (check if bilateral___): 27446, 27447

☐ Tonsillectomy and/or Adenoidectomy: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
☐ Varicose Vein Surgery: 37700, 37720, 37730, 37735, 37780, 37785

Appendix 27
Second Opinion Elective Surgery Request/Physician Report Form
(for photocopying)
Second Opinion Physician Information

Note: The physician performing the second opinion must complete this side of the form.

Physician Name: __________________________________________________________________________________

Address: __________________________________________________________________________________________

________________________________________________________________________________________

Telephone: _______________________________________________________________________________________

Medicaid Provider Number: __________________________________________________________________________

Findings (include any information on alternative treatment, additional medical tests, or other significant findings):
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Check One:  
☐ I agree with the need for the surgery.
☐ I do not agree with the need for the surgery.

Comments: _______________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Physician’s Signature: __________________________________ Date: __________________________________________

Following the recommending surgeon’s request indicated on the front page, return this form to one of the following:

• Alternative #1: Return to Recommending Surgeon (Name and address listed on front page)

• Alternative #2: Mail to: SSO Department
  Medicaid Fiscal Agent
  6406 Bridge Road
  Madison, WI 53784-0012