MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

SECOND SURGICAL OPINION

MO-8807

SECTION I TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN — PLEASE PRINT OR TYPE

PARTICIPANT'S NAME (FIRST) (M.I.) (LAST)			PARTICIPANT'S MO HEALTHNET NUMBER
SURGICAL PROCEDURE DISCUSSED AND RECOMMENDED		CPT PROCEDURE CODES	ICD-9-CM DX CODE
PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS			
PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)		PHYSICIAN'S MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
PHYSICIAN'S OFFICE ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)			SPECIALTY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF PRIMARY PHYSICIAN		DATE

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PARTICIPANT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS		
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED		CPT PROCEDURE CODES	ICD-9-CM DX CODE
SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)		PHYSICIAN'S MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)			SPECIALTY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN		DATE

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A THIRD SURGICAL OPINION IS COVERED BY MO HEALTHNET IF THE SECOND SURGICAL OPINION PHYSICIAN DID NOT RECOMMEND SURGERY)

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS		
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED		CPT PROCEDURE CODES	ICD-9-CM DX CODE
THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)		PHYSICIAN'S MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)			SPECIALTY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN		DATE

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF PARTICIPANT

SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED			CPT PROCEDURE CODES
ICD-9-CM DX CODE	SPECIFY NAME AND ADDRESS OF SURGERY SITE		
DATE OF SURGERY			
SURGEON'S NAME (FIRST) (M.I.) (LAST)		PHYSICIAN'S MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
SURGEON'S OFFICE ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)			SPECIALTY, IF APPLICABLE
PERSONAL SIGNATURE OF SURGEON			DATE

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MO HEALTHNET CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MO HEALTHNET FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.