

# SECOND SURGICAL OPINION STATEMENT AND INSTRUCTIONS

Send to:



**ASSURECARE®**

Assured Access Health Systems Management  
13700 Watertower Circle, Suite D  
Plymouth, MN 55441  
Phone: (800) 328-0927  
Fax: (763) 383-4880

Please refer to your employee benefit plan booklet for specific details about actual payment and other important information. Completion of this form and the surgeon's opinion does not constitute verification of benefits.

1. Employee please complete Part I. Be sure to ask your doctor for the complete name of the surgical procedure that he/she recommends (\*Item #8\*)
2. If you wish to assign benefit to the specialists you must complete the assignment of benefit statement.
3. The board-certified specialists must fully complete the physician statement.
4. Return the completed form to AssureCare (above address).

**IMPORTANT:** THE FINAL DECISION ON WHETHER OR NOT TO HAVE THE ORIGINALLY RECOMMENDED SURGERY PERFORMED IS ALWAYS UP TO THE PATIENT OR PATIENT'S FAMILY.

## PART I EMPLOYEE TO COMPLETE

1. EMPLOYER		
2. EMPLOYEE		
3. EMPLOYEE ADDRESS		
4. PATIENT NAME	5. DATE OF BIRTH	6. SEX
7. NAME AND ADDRESS OF SURGEON WHO FIRST RECOMMENDED THIS SURGERY		
8. NAME OF SURGICAL PROCEDURE RECOMMENDED		

## ASSIGNMENT OF BENEFIT STATEMENT

I hereby authorize payment directly to the Undersigned Physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described in Part II of this form, but not to exceed the reasonable and customary charges for those services.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(continued on reverse)

**PART II –****PHYSICIAN TO COMPLETE**

You have been selected for a second opinion regarding the need for proposed surgery, possible alternative treatment plans and the advisability of selected surgery being performed on an out-patient basis.

1. Medical history with physical findings (please include results of diagnostic studies and procedures).

2. In your professional opinion, do you consider the recommended surgical procedure medically necessary?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please Comment:

3. Would you advise the recommended procedure be performed on an out-patient basis?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please Comment:

4. Would you recommend alternate medical treatment in lieu of surgery here?

Please Comment:

5. Did the patient provide you with a copy of his medical record?

Yes \_\_\_\_\_ No \_\_\_\_\_

6. Date of Service	Fully describe procedure, medical services furnished	Charges

I CERTIFY THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE NO FINANCIAL RELATIONSHIP WITH THE NAMED PRIMARY SURGEON.

PHYSICIAN SIGNATURE

DATE

PHYSICIAN NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER

FEDERAL I.D. #

SPECIALTY