Funding request: cardiac follow up consultation

Instructions for completion

Please complete this form to request funding for a Bupa patient to have an additional cardiac follow up consultation and tests. It's important that you complete all the questions so that we can check whether the consultation is covered by the patient's health insurance policy. Without all the information we may need to ask you for more details and this could cause a delay. We may also need to see a copy of the patient's full medical notes, which we'll request from you or the patient's GP.

Please send your completed form to us by secure email to: CardiacSupportteam@bupa.com.

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress Switch. For more information and to sign up for a free Egress Switch account, go to https://switch.egress.com/ui/learn. You won't be charged for sending secure emails to a Bupa email address using the Switch service.

We'll let you know within two working days of receiving the completed form whether the patient's policy covers the consultation.

If the patient needs an additional follow up consultation please ask them to pre-authorise it with us. This is important because their policy may not cover further consultations if their condition is chronic.

If you've any questions please call: 0345 600 7264†. We're here between 8am and 8pm Monday to Friday and 8am to 4pm Saturdays.

About the patient	About the consultant
Name:	Name
Bupa Membership Number	Bupa Provider Number:

About the patient's condition	
Is this a new cardiac condition? ☐ Yes ☐ No	Is this an exacerbation of a previous diagnosed cardiac condition? ☐ Yes ☐ No
Is this surveillance of an ongoing cardiac condition? ☐ Yes ☐ No	If yes, can you confirm the patient has been assessed and referred by his/her GP for this exacerbation? ☐ Yes ☐ No
Please provide details of past cardiac medical history, including the dates of cardiac interventions and other relevant information:	Please explain the need for a further follow up consultation:

Declaration

Please complete the section below to confirm that the information above is accurate to the best of your knowledge, and that the patient (or their representative) has given permission for it to be shared with us.

Consultant cardiologist's name:

Consultant cardiologists signature:

General Medical Council number: Date:

†We may record or monitor our calls.