High dependency or intensive therapy unit stays

Funding request form

Please complete this form to request Bupa funding for your patient to stay in a high dependency unit (HDU)/ intensive therapy unit (ITU)

Our customers' healthcare schemes may cover the cost of a HDU/ ITU stay if the patient meets Intensive Care Society (ICS) criteria for Level 2 and Level 3 care[1]. If so, we may ask you for a copy of the patient's full medical notes to check that the care is covered.

Please complete all sections of this form. Without all the information, our response to your funding request may be delayed.

Please return the completed form to us by email to: **caresupportteam@bupa.com** If you need to send us sensitive information you can email us securely using Egress^.

We'll let you know by email within three working days of receiving the completed form whether cover is available.

If you've any questions please call us on: **0345 266 9685**. We're here between 8am to 6pm Monday to Friday and happy to help.

1. Patient and hospital information

Patient's name		
Bupa membership number		
Date of hospital admission	D D M M Y Y Y Y	
Has the patient had a pre-op night?	☐ Yes	☐ No
Name of next of kin or authorised contact		
Phone number for next of kin or authorised contact		
Hospital contact name		
Responsible (lead) consultant		
Hospital phone number		
Date of birth	D D M M Y Y Y Y	
Does the patient meet the ICS eligibility criteria for care[1]?	☐ Yes	☐ No
Was the patient transferred into this Level 2/3 unit for eligible private treatment following at least 24 hours of Level 0/1 care?	☐ Yes	☐ No
Number of nights requested		
Was the patient on a private ward for 24 hours before transfer to ITU/HDU?	☐ Yes	☐ No
Reason for admission to ITU/HDU		

1Levels of critical care for adult patients. Intensive Care Society
*We may record or monitor our calls.
^For more information and to sign up for a free Egress account, go to https://switch.egress.com. You won't be charged for sending secure emails to a Bupa email address using the Egress service.

2. Information about the patient's condition

Patient's name	Date of birth D D M M Y Y Y Y
Diagnosis	Bupa membership number
Comorbidities	

	Day 1	Day 2	Day 3	Day 4	Day 5
Date					
Level of care					
HDU Level 2	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ITU Level 3	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have organ failure?					
If yes, is it single organ failure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Which organ(s)?					
Respiratory care					
Is the patient ventilated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation type/mode					
Oxygen					
Litre/Min (%)					
SPO2% Range					
Respiratory rate					
ABG abnormalities and lactate					
Cardiovascular					
Heart rate and rhythm					
Blood Pressure Range					
Is the patient receiving vaso-active drugs? If yes, please provide details	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the patient receiving invasive monitoring? If yes, please provide the CVP reading:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arterial Line in situ	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Clinical information continued

	Day 1	Day 2	Day 3	Day 4	Day 5
Date					
Renal monitoring					
Urine output (mls/hour)					
Is the patient receiving haemofiltration	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the patient receiving dialysis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Electrolyte levels					
Urea					
Creatinine					
K+					
CRP					
Has the patient had a blood transfusion?					
If yes, please provide the values:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Units					
HB					
Neurological sedation					
Has the patient received neurological sedation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Glasgow Coma Score (3 -15)					
Neurological monitoring in situ	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has the patient received analgesia?					
Epidural thoracic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Epidural lumbar	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Block	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PCA	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other, please give details					

3. Consultant's declaration

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity to do so before I submitted this form.

Consultant's name

Date completed D D M M Y Y Y Y

General Medical Council number

Nurse's Name

Date completed D D M M Y Y Y Y

Job title

Nursing and Midwifery Council (NMC) Pin

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