Spinal surgery

Funding request form

Please complete this form to check whether the Bupa patient's policy covers spinal surgery for lower back pain or surgical management of radiculopathy.

Please complete each section of the form, as it captures all the information we need to determine whether the proposed treatment is covered by the patient's healthcare policy. Incomplete forms or evidence is likely to delay our funding decision and the patient's treatment.

Please return this form to us by secure email to: backcareteam@bupa.com

Information you send us by email isn't usually secure until it reaches us. We use secure email provided by Egress. You can sign up for a free account at https://switch.egress.com. You won't be charged to send secure emails to a Bupa email address using this service.

If you've any questions please call us on **0345 600 8277** between 9am to 5pm, Monday to Friday or you can use webchat between 8am to 6pm Monday to Friday (we may record or monitor our calls).

Patient's details

Title (please tick)	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ Other (please state)
Patient's name	
Date of birth	D D M M Y Y Y Y
Bupa membership number	

Clinicians' details

Name of consultant
Bupa provider number
Name of hospital
Name of anaesthetist
Anaesthetist's Bupa provider number

Diagnosis and medical history

Please give details of the patient's diagnosis and history of the condition (including the relevant ICD 10 code)

Proposed treatment

Please give the CCSD code(s) for the primary procedure(s)

CCSD code(s) secondary procedure(s)

Will two consultants carry out this surgery? ☐ Yes ☐ No

If yes, please give the second consultant's name

Second consultant's Bupa provider number

Proposed admission date D D M M Y Y Y Y

Expected discharge date D D M M Y Y Y Y

Is this surgery staged? ☐ Yes ☐ No

If yes, please give the following for the second stage:

CCSD code(s) for the primary procedure(s)

CCSD code(s) for the secondary procedure(s)

If any of the clinicians will change for the second procedure, please give their names and Bupa provider numbers below

Will two consultants carry out this surgery? ☐ Yes ☐ No

If yes, please give the second consultant's name

Second consultant's Bupa provider number

Multi-disciplinary team (MDT) details

Was an MDT meeting comprising of at least two spine surgeons, a radiologist or neuroradiologist and other specialities as needed carried out?

☐ No. If no, please give the clinical rationale as to why not

Then please move to the Supporting Information section and complete the rest of the form from there.

☐ Yes, please give the:

Date of MDT D D M M Y Y Y Y

Hospital name

Name of first surgeon

General Medical Council (GMC) number

Name of second surgeon

GMC number

Name of radiologist or neuroradiologist

GMC number

We may ask for a copy of the MDT meeting minutes if we need more information to help us check whether the treatment is covered by the patient's scheme.

If you've completed the table above, please skip to Consultant's declaration.

Supporting information

Did the patient have conservative treatment before surgery was offered as an option in line with the National Back Pain and Radicular Pain Pathway 2017 (page 4)?

☐ Yes. We may need to see copies of the patient's notes to confirm cover

☐ No. Please give the clinical rationale for not trying conservative treatment

Can you confirm that this surgical case and any associated complication(s) will be recorded on the British Spine Registry or Spine Tango in line with GIRFT recommendation No. 14. (page 11)?

☐ Yes. Which registry did you use?

☐ No. Please give the clinical rationale for not including this case on a register

Can you confirm that recognised Patient Reported Outcome Measures (PROMs) have been recorded before surgery and that these will be recorded at appropriate intervals post-surgery in line with National Low Back and Radicular Pain Pathway (page 4)?

☐ Yes. Which PROMs will be used?

☐ No. Please give the rationale for not using PROMs

Consultant's declaration

I understand that the clinical information I've supplied may be considered as 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 D D M M Y Y Y Y

General Medical Council number