Left atrial appendage occlusion

Funding request form

Please complete this form to request funding for Bupa patients who need Left atrial appendage occlusion treatment, such as Watchman, Atriclip etc. We fund treatment covered by the patient's policy that's in line with published evidence-based guidelines.

Please type this form and complete all sections. Without the information requested, our funding decision may be delayed. We may need to see a copy of the patient's full medical notes, which we'll ask you for, to confirm that the treatment is covered by the patient's policy.

Then send your completed form and supporting information to us as soon as possible by secure email: **CardiacSupportteam@bupa.com**. Information you send to this email address may not be secure unless you send us your email through Egress Switch. To sign up for a free Egress Switch account, go to **https://switch.egress.com**

We'll let you know by phone or secure email within two working days of receiving your completed form whether the Bupa patient's treatment is covered by their policy. Please let us know how you'd prefer us to contact you about this?

Phone ☐ or secure email ☐

What's the best phone number/email address to use?

If you've any questions please call us on **0345 600 7264**. We're here between 8am and 8pm Monday to Friday and 8am to 4pm Saturdays. We may record or monitor our calls.

1. About the patient

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

2. Clinician's details

Name of requesting consultant
Bupa provider number
Specialty
Hospital name
Phone number

3. About the patient's condition

Please give details of the clinical picture for the patient

What is the patient's non-valvular atrial fibrillation CHA2DS2-VASc Score?

Has the patient been reviewed by a multidisciplinary team? (this isn't necessary for Atriclip)

4. Questions about the proposed treatment

Please give details of what open cardiac surgery is taking place alongside the request for the Atriclip procedure

What are the clinical indications for left atrial appendage occlusion? Please explain why oral anticoagulation (including the newer direct thrombin or Factor Xa inhibitors) are not indicated

What is the make and model of the device being used?

How much does the device cost?

What's the reason for using this specific device?

When is the proposed implantation date? D D M M Y Y Y Y

At which hospital will implantation take place?

4. Consultant's declaration

Please complete this section to confirm that the information on this form is accurate and not misleading, that you've obtained informed consent from the patient and have explained all the risks and alternatives associated with this treatment.

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 before I submitted this form.

Consultant's name

General Medical Council number

Date D D M M Y Y Y Y