Ablation procedures

Funding request form

Please complete this form to request funding for Bupa patients with atrial fibrillation (AF) who need ablation procedures. If a Bupa patient needs more than one follow-up appointment after an ablation, we may ask you for further information to check whether this is covered. Please make sure that all diagnostic tests are complete and a definitive decision has been made to proceed to atrial fibrillation ablation before submitting this funding request.

We'd be grateful if you could give us enough time before treatment begins. We may need to see a copy of the patient's full medical notes, which we'll request from you or the patient's GP, to confirm eligibility for funding. We'll let you know within two working days of receiving your completed form whether the Bupa patient's treatment is eligible for funding.

Please type this form and complete all sections. Without the information requested, our funding decision may be delayed. Then send your completed form 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/ui/learn.

If you've any questions please call us on: **0345 600 7264**† or: **0345 755 3333**^.

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	
Name of hospitals	

2. Details of the treating consultant

Name	
Bupa provider number	Phone number
General Medical Council number	

3. About the patient's condition

Is this ablation procedure part of the treatment for atrial fibrillation? (If no, please skip to the Declaration, complete that and return the form to us)	☐ Yes	☐ No
Please select the type of atrial fibrillation planned	☐ Paroxysmal	☐ Persistent
How long has the patient had AF?	☐ Less than a year	☐ More than a year

4. Current symptom status

Is the patient significantly limited by symptoms likely to be due to atrial fibrillation?	☐ Yes	☐ No
Has rate control treatment been optimised for patients with persistent AF?	☐ Yes	☐ No

†Lines are open 8am to 8pm Monday to Friday, and 8am to 4pm Saturday. We may record or monitor our calls.
^Lines are open 8am to 6pm Monday to Friday, and 8am to 1pm Saturday. We may record or monitor our calls.

5. Pre-authorisation form: Ablation procedures

Please state rate controlling medications used, if any, including dosage

What is the patient's left atrial (LA) size on echo

- ☐ Normal
- ☐ Mild
- ☐ Moderate
- ☐ Severe dilatation
- ☐ Volume (Simpson's method) (45-55, 40-45, 35-40, <35)
- ☐ Maximum 2D dimension (<3.5cm, 3.5cm-4cm, 4-4.5cm, 4.5-5cm, 5-5.5cm, 5.5-6cm, >6cm)

What is the patient's left ventricular ejection fraction (%)? ☐ 0-25% ☐ 25-35% ☐ 35-40% ☐ 40-50% ☐ >50%

Does the patient have valvular heart disease?

- ☐ Yes, please give details below
- ☐ No

Is it likely that the cause of the patient's AF is reversible?

- ☐ Yes, please give details below
- ☐ No

Has the patient had attempts at cardioversion? Please include date(s) of any procedures

- ☐ No cardioversion
- ☐ 1 cardioversion
- ☐ 2 cardioversions
- ☐ 3 cardioversions

Has the patient had previous attempts at ablation for AF? Please include dates of any procedures

- ☐ No previous AF ablations
- ☐ 1 AF ablation
- ☐ 2 AF ablations
- ☐ 3 or more AF ablations

If 3 or more previous ablations, please confirm that the patient's management has been discussed in a formal MDT including another cardiologist

- ☐ Yes, please provide the name of the cardiologist below
- ☐ No

Please give any other relevant information, including the proposed treatment plan and rationale for it

6. Declaration

Please complete this section to confirm that the information in this form is accurate to the best of your knowledge.
By completing this form, you certify that the patient named above has given their permission for this information to be shared with us in accordance with the terms of their Bupa healthcare policy.

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 cardiologist's name

Email address

Date

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FEB19