Breast cancer patients

Treatment plan form

Please complete this form to pre-authorise treatment for Bupa patients with breast cancer.

Please type this form and complete all sections. Without the information requested we'll need to ask you for more information to let you know whether the plan is covered and give you pre-authorisation numbers*.

Send your completed form as soon as possible by secure email to Treatmentrequest@bupa.com

Information you send to this email address may not be secure unless you send us your email through Egress. To sign up for a free Egress account, go to https://switch.egress.com/ui/learn

We'll let you know by secure email within one working day of receiving your completed form whether the Bupa patient's treatment is covered by their policy.

What's the best email address to use?

If you've any questions please email us at **Treatmentrequest@bupa.com** (we're here between 9am and 4pm Monday to Friday, and are happy to help).

1. About the hospital

Hospital name	Bupa provider number
Contact name	
Email address	Phone number

2. About the clinician

Name of lead consultant
Bupa provider number

3. 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	
Address	

*You'll still need to invoice Bupa in the usual way after the patient has been treated. Pre-authorisation doesn't guarantee funding but provides an indication of eligibility of the treatment to be delivered to the patient, based on the information shared at the time the authorisation is sought.

4. About the patient's condition

Primary diagnosis

Staging ☐ TX ☐ NX ☐ MX

(Please include TNM staging for Malignant Tumours. Node and Metasis fields are optional dependent on information available at the time of completing Treatment Plan.)

Date of diagnosis D D M M Y Y Y Y

Performance status

Allergies

Please give results of any genetic, receptor status or molecular profiling tests

Co-morbidities

Treatment history (please give details of all the patient's previous treatment with start and end dates)

5. About the planned treatment

Diagnostic tests

Please give details of all planned diagnostic tests

Surgery (please skip if this doesn't apply)

Procedure codes

Surgery date D D M M Y Y Y Y

Hospital

Consultant

Anaesthetist

Radiotherapy (please skip if this doesn't apply)

Type of radiotherapy

Type of planning

Number of fractions

Consultant

Hospital

5. About the planned treatment (continued)

Drug treatment and planned supportive medicines (please skip if this doesn't apply)

Drug name	Drug dose (mg/kg)	Number of planned cycles	Route of administration	Hospital	Lead consultant

6. 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 before I submitted this form.

Name

Date D D M M Y Y Y Y

General Medical Council/Health and Care Professions Council number (if applicable)