Funding request form: Abdominoplasty

Please complete this form to check whether your Bupa patient's healthcare policy or scheme covers an abdominoplasty procedure.

Abdominoplasty surgery may be covered if it is likely to cure an acute condition and is in line with best practice in the UK.

Completing the form

- Please fill out all sections of this form.
- Include a summary of the patient's anticipated benefit(s) and published evidence.
- Email the completed form to us at: skinteam@bupa.com at least four working days before the surgery is due to take place:

If you need to send us sensitive information you can email us securely using Egress^.

We'll let your Bupa patient know by email or call within three working days of receiving the completed form if the treatment is covered. You can check if the patient's treatment has been preauthorised quickly and easily using Providers Online

If you've any questions, please use the email addresses above and we'll be happy to help.

1. Patient's information

Title (please tick) ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Dr ☐ Prof ☐ Other (please state)

Patient's name:

Date of birth: D D M M Y Y Y Y

Patient's phone number:

Bupa membership or registration number:

2. Clinician's information

Consultant's name:

Bupa provider number:

Phone number:

Hospital name:

3. About the patient's condition

Does the patient have a hernia?

☐ Yes ☐ No

If yes, please give details of the hernia and why abdominoplasty is the most appropriate treatment.

^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.

3. About the patient's condition

What are the alternative treatment options?

What is the patient's current BMI?

How long has the patient's BMI been at its current level (in months)?

What was the patient's BMI prior to weight loss?

What percentage of the excess (not overall) weight has the patient lost?

Is further weight loss possible?

☐ Yes ☐ No

Is the excess tissue causing functional problems?

☐ Yes ☐ No

If yes, please give details of the functional impairment?

Has the excess tissue caused recurrent infections?

☐ Yes ☐ No

If yes, please give details of the recurrent infections.

4. About the proposed treatment

Please give details of the planned procedure, the clinical rationale for it, and expected outcomes.

5. 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 D D M M Y Y Y Y

General Medical Council number

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