

Bupa health insurance

Important points about your Bupa patients' cover















Bupa 

Keeping things simple

This booklet explains important points about your Bupa patients' cover. It'll give you an overview of our standard health insurance policies.

Health insurance covers unexpected illnesses or injuries that begin after the start of the policy.

Information to help you

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Our health insurance policies

The policies your Bupa patients or employers choose can differ. For example, whether they include an excess or co-payment or apply an outpatient allowance. Here are some of these options in more detail.



Excesses and co-insurance

Patients may have an excess or co-insurance on their policy. This means they pay an agreed amount towards treatment covered by their policy. An excess applies to each person covered by the policy and for each policy year.

Every time the patient's policy renews their excess also resets. So if they're having treatment when they renew, they may need to pay two excesses - one for the previous policy year and the other for the new one.

Patients may also have a co-insurance, which means they pay an agreed proportion of each claim up to a maximum amount in a policy year. The rest of the claim is covered by their policy, up to their benefit allowance. Co-insurance applies to each person covered on the policy, each year.



Need to know:

We'll let the patient know that they'll need to pay the excess or co-insurance to their consultant, therapist or recognised hospital or clinic.

Hospital networks

We offer a choice of hospital networks which all include quality assessed UK hospitals. Some network options include fewer hospitals - for example central London hospitals (where treatment is usually more expensive than elsewhere). You can find more information about our hospital networks on page 30.

Outpatient allowances

Many policies cover all stages of care and have a yearly outpatient allowance. This usually covers hospital or clinic appointments with consultants and therapists, diagnostic tests, treatments (which aren't classified as a surgical procedure) and x-rays. Once a patient has used up their allowance, they'll need to pay for any further outpatient treatment themselves.

Some policies don't cover any outpatient charges, including diagnostics, unless they follow inpatient treatment covered by the patient's policy.

Treatment is only covered as long as the patient is seeing a recognised healthcare professional at a recognised hospital or clinic in the hospital network they've chosen.



Underwriting

Underwriting is the way health insurers use someone's personal and health information to decide what cover they can offer. We offer two main underwriting options: Full Medical and Moratorium.

Full medical underwriting

Full medical underwriting means that we use information about patients' medical history to confirm what cover we can offer them before their policy starts. Medical conditions that they, or anyone on their policy, had before they take out insurance with us aren't usually covered.

When patients choose full medical underwriting, we'll ask them some questions about their medical history. We'll use the information they give us to confirm what cover we can offer them for their medical conditions. We may need to ask their doctor for more information to help us do this.

Patients choose full medical underwriting so they can be certain about what is and isn't covered from the start of their policy. Any new medical conditions after their policy starts will be covered in line with the policy terms and conditions. They may not be covered for any medical conditions that they or anyone else on the policy already have (including any related conditions) when they take out the policy.

Moratorium underwriting

Moratorium underwriting starts when the patient makes a claim instead of when they take out the policy. This means they don't need to give us their medical history before their cover begins. If they've had a medical condition before joining us, it may not be covered, depending on their policy.

We check information with the patient's GP each time they claim so that we can confirm whether the condition they're claiming for is new or if they had it before their policy started.

If the condition is new, we'll cover it in line with the patient's policy. If they had the condition before their policy started, it may be covered as long as they've not had any symptoms, treatment or medical advice for it for two consecutive years since the policy started. If the patient hasn't been symptom or treatment free, the moratorium period for the condition is extended by two years from the date the patient last had symptoms or received treatment.



Need to know:

Patients with health insurance via their employer may have other options depending on the policy or whether they're transferring from another Bupa policy or insurer.

There are some things health insurance doesn't usually cover. These are known as general exclusions, for example:

- the maintenance of chronic conditions
- sleep problems
- treatment of allergies
- cosmetic surgery
- pregnancy.

Your patients can find details about what is and isn't covered in their policy guides.





How your patients' cover works

Health insurance gives patients fast access to private care for acute conditions which are covered by their policy, start after their policy begins and are in line with their underwriting terms (please see page 6 for more details). An acute condition is a disease, illness or injury that is expected to respond quickly to treatment and get people back to their previous level of health. Health insurance doesn't usually cover chronic conditions – you can find out more about this below.

Our health insurance covers the cost of:

- medically necessary, planned private consultations, tests and treatment for acute conditions
- consultations and treatment from consultants we work with (Bupa recognised consultants)
- care at Bupa recognised hospitals and clinics.

Where a consultation, test or treatment isn't covered, it doesn't mean that it's not medically necessary. It just means that it's not in line with patients' policy terms.

Chronic conditions

Like most other health insurers, our health insurance policies don't usually cover the treatment and care of chronic or long term conditions. We use the Association of British Insurers' (ABI) definition of chronic conditions. This is:

A disease, illness or injury which has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.



It's important to note, we don't consider cancer or mental health as chronic conditions.

What this means in practice

Chronic or long-term conditions often need consultations over a long period, checks on medication, long-term therapy or treatment to keep a condition or its symptoms under control. When this happens, treatment for the ongoing management of the condition isn't usually covered by patients' policies because the symptoms are either expected, or part of the condition's natural progression.

What's covered?

Patients' policies may cover them for diagnosis and some tests if they're unwell. However, once a chronic condition is diagnosed, health insurance cover may not be available. They'll usually need to transfer to the NHS for the ongoing management, screening and monitoring of the condition.

Or they may decide to self pay for private treatment with you.

If your Bupa patient experiences an unexpected acute flare-up, their policy may cover a short course of treatment that can treat or cure the symptoms. Our policies cover this treatment when the condition is likely to respond quickly and the treatment aims to restore them to their previous level of health immediately before the acute flare-up.

Health insurance doesn't cover treatment received in A&E, walk in centres or urgent care centres. If urgent care is needed to help stabilise or treat a Bupa patient's condition, they should use NHS emergency services. However once the patient's condition has stabilised and if their consultant agrees that they're well enough, they may be able to transfer to private care for any treatment needed so long as their condition and the treatment are both covered by their policy.

See page 12 for more information about emergency treatment.



Transfer of private patients to the NHS

Health insurance is intended to complement the NHS. Patients may need to return to the NHS if treatment for their condition is no longer covered by their policy, or pay for it themselves if they'd prefer to continue privately.

Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient. However a patient can't be both a private and an NHS patient for the treatment of the same condition during a single visit to the NHS.

Once it's established that the patient's treatment is no longer covered by their policy, the consultant treating them should make sure they're able to seek appropriate treatment and care in the NHS. Patients referred for an NHS service after a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service.

You can read more about private and NHS care interaction in BMA Medical Ethics Department's guidance.

An example of how our cover works

The following fictional example is designed to show how some of our policies work. Please bear in mind that, where we say a treatment or consultation isn't covered by a patient's health insurance, it's usually due to the general exclusions that apply to their policy – it doesn't mean that their treatment or consultation is not medically necessary.



Angina and heart disease

Arjun has had Bupa health insurance for many years. He develops chest pains and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as having the heart condition angina. Arjun is placed on medication to control his symptoms.

Will Arjun be covered?

Arjun's health insurance covers the private consultations and the initial tests he needs to help diagnose his condition. Arjun can then go back to the NHS for the ongoing check-ups he needs to monitor his condition.

What if Arjun's condition gets worse?

Two years later, Arjun's chest pains comes back and is worse. His specialist recommends that he has a heart bypass operation.

Arjun needs to contact us about this new referral, so we can confirm whether his consultation is covered by his policy, which it is. The bypass operation will be covered as well as his follow-up consultations, so his consultant can check how he's doing afterwards.

If he needs more monitoring, such as regular check-ups, these won't be covered so Arjun will have to go through the NHS or he may choose to pay for these himself.



Is emergency treatment covered?

Any accident and emergency treatment, including immediate care, provided by an NHS A&E, urgent care centre or walk in clinic or within a private facility isn't covered.

If after an NHS or private emergency admission a patient needs further hospital treatment privately, some treatment may be covered. This depends on what policy the patient holds. Please call us to understand what is covered.

Is intensive care treatment covered?

Our policies cover intensive care when it follows an eligible admission to a Bupa recognised hospital or clinic with a critical care unit where the patient has been receiving Bupa funded private treatment. The cost of transferring a patient from an NHS hospital or clinic to intensive care in a Bupa recognised hospital or clinic, or vice versa, isn't covered unless:

- the patient was transferred from an NHS critical care unit to an NHS general ward for more than 24 hours; and
- their consultant agrees that they're well enough to move; and
- we've confirmed that their care is covered by their policy.

If a patient develops an unexpected complication after receiving Bupa funded private treatment in a hospital or clinic that doesn't have its own critical care unit, we may cover their transfer to another Bupa recognised hospital or clinic. Please call us to check before moving the patient.

Alternatively, consultants should arrange for their patient to transfer to the nearest NHS hospital or clinic with a critical care unit.



Tip:

You can check if intensive care is routinely covered after a planned procedure using our code search at codes.bupa.co.uk.

Codes marked with an (i) mean that intensive care is routinely required after that procedure. We list the maximum number of days that we'll routinely cover for both the general ward and critical care unit against the procedure.



Tip:

You can check whether intensive care is available at a Bupa recognised hospital or clinic by searching on finder.bupa.co.uk.

If a patient needs critical care, you'll need to send us a completed funding request form so that we can confirm whether the patient's policy covers their care.

You can do this quickly and easily by logging into **Providers Online** and selecting the forms option in the left-hand menu. Search for the patient needing treatment, then select the form you need and follow the steps.

Please don't transfer the patient until we've let you know that their care is covered.





Cover for drugs, new and experimental treatment and appliances

Our health insurance gives patients access to innovative drugs, treatments and therapies as long as they're covered by the patient's policy. However, our policies don't cover everything so please check with us before prescribing or going ahead with treatment.

Take home medication and separately chargeable drugs

We cover the cost of drugs patients receive as part of their inpatient stay, and the cost of these drugs is usually included in the price we pay the hospital for the patient's care.

Drugs prescribed for outpatient treatment, or for the patient to take home when they leave hospital, aren't covered by our policies.

Patients need to pay for these themselves. The only exception is when the treatment is licensed for cancer and when this happens, the hospital can charge us separately.

We have agreements with most Bupa recognised hospitals to give patients enough drugs for a few days so that they can go home and get the remainder of their treatment from their GP. However, some specialist drugs can be expensive so we have a list of those that hospitals can charge separately for. They need to get a pre-authorisation from us before giving any of the drugs on the list to a Bupa patient.

The Separately Chargeable Drugs List (SCDL) can be found **online**.

Drugs to treat chronic or special conditions

When a patient has treatment that isn't covered by their policy or for a chronic condition, any drugs they're given as part of this aren't usually covered.

Some Bupa patients may have specific pre-existing medical conditions which aren't covered by their policy, so any treatment, drug or any other medical intervention linked to these is also not covered.

Cover for new treatments

Our health insurance policies cover treatments that are:

- ✓ consistent with generally accepted standards of medical practice,
- ✓ clinically appropriate in terms of type, frequency, extent, duration and the hospital/ clinic or location where the services are provided; and
- ✓ demonstrated through scientific evidence to be effective in improving health outcomes.

We want to give our customers fast access to breakthrough drugs and treatment. For cancer, we cover chemotherapy and advanced therapies (for example gene therapy medicines, somatic-cell therapy medicines and tissue-engineered medicines). Call us to find out if the drug therapy is covered by your patient's policy.

We may cover drugs or treatment if it aims to provide a cure or restore the patient to their previous level of health immediately before the acute illness or flare-up.

If the drugs or treatment are only given to manage or temporarily relieve symptoms of a chronic condition, they aren't usually covered.



Experimental, unproven, and out-of-licence treatment

Our policies don't cover treatment which we believe is experimental or isn't proven and established UK medical practice. This includes drugs outside the terms of their licence or procedures which haven't been satisfactorily reviewed by NICE.

In some instances, we can make exceptions to offer access to eligible breakthrough cancer drugs and treatments often before they are available on the NHS or approved by NICE as long as they are evidence-based.

Out-of-licence drugs

Our policies may cover the cost of some unlicensed cancer drugs or drugs being used outside of their licence indications. If a patient needs one of these, their consultant will need to send us a completed form which can be found **online**.

We'll let the consultant know whether the proposed treatment is covered by the patient's policy within three working days of receiving the form. Please give us as much time as possible before treatment is due to begin to avoid delays.

When looking at whether we can cover out-of-licence drugs, we review the strength and quality of the clinical effectiveness evidence and the anticipated measurable outcomes. These may include improvements in overall survival, progression-free survival, clinical response, and adverse effects.

Prosthesis and appliances

The cost of appliances that patients take home after a procedure, such as a plaster cast, or any high cost consumable that's needed to perform a procedure is included in the hospital's charges. This means there's no need for hospitals or consultants to bill us separately for these.

However, occasionally our policies cover the cost of some appliances or prosthesis that are an essential and integral part of the surgical procedure, which won't be successful without them.

We have a list of prostheses and appliances that we'll cover separately, and review funding requests for these on an individual basis. The list is available online in the Prosthesis and Appliances section of our Schedule of Procedures at **bupa.co.uk/prostheses-and-appliances**.

Our agreements with Bupa recognised hospitals and clinics vary and some may have different terms for appliances and high cost consumable charges.





Patient referral and pre-authorisation

If a Bupa patient wants their health insurance to cover the cost of seeing a specialist or consultant, they normally need to have a GP referral or a referral from another healthcare professional if a GP appointment isn't clinically necessary.

There are some conditions where a GP referral isn't usually needed. If patients have Direct Access included as part of their cover, they can access specialists for cancer, mental health and musculoskeletal conditions.

You can find out more about this at bupa.co.uk/direct-access.

If the patient's policy doesn't include Direct Access and they need to see a GP for a referral, they should ask for an 'open referral'. This means that the GP decides the type of consultant (e.g. orthopaedic surgeon or gynaecologist) they need to see for tests and/or treatment. The only exception is when a paediatric referral is required, then a GP will need to recommend a paediatrician by name.

When a Bupa patient calls us to arrange their consultation, test(s) or treatment, we use the information from the GP or healthcare professional to offer them a choice of Bupa recognised consultants with the appropriate medical skills and expertise who are covered by their policy. We'll also confirm the policy benefits available and give them a pre-authorisation number so the healthcare professional they see can use this when they bill us.



Patients can use Finder, our comprehensive online directory, to search for Bupa recognised healthcare professionals and services.

finder.bupa.co.uk





When we ask for information



We work hard to make sure we meet our regulatory requirement to treat our customers fairly and apply the terms of their policies consistently. This means we might need to ask their consultant for some information before we can confirm whether their policy covers their treatment.

When this happens, we'll need the patient's permission before we ask their doctor for more information, in writing, about their consultation, tests or treatment for insurance purposes. The Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (NI) Order 1991 gives patients certain rights which are:

1. They can give permission for their doctor to send us a medical report without asking to see it before they do.
2. They can give permission for their doctor to send us a medical report and ask to see it before they do.
3. They can withhold their permission for their doctor to send us a medical report. If they do, we'll be unable to see whether the consultation, test or treatment is covered by their policy, so won't be able to give them a pre-authorisation number or confirm whether we can contribute to the costs.

They'll also have the right to ask their doctor to let them see a copy of their medical report within six months of it being sent to us. The doctor can withhold some or all of the information in the report if in their view the information:

- might cause physical or mental harm to the patient or someone else or
- it would reveal someone else's identity without their permission (unless the person is a healthcare professional and the information is about the patient's care provided by that person).

If we ask for a medical report, please make sure that your reply is suitably detailed and includes all information you think is relevant and helpful so that our qualified clinicians can see whether the patient's care is covered by their policy.

If we're unable to cover the treatment, it usually doesn't mean we believe that it's clinically inappropriate, it's because it's not covered by the patient's policy. For example, we wouldn't cover the ongoing treatment of a chronic condition, even though this treatment may be necessary.



Consultations and procedures

Our policies cover consultations between a healthcare professional and a patient to review their symptoms, diagnose their condition and to discuss the next steps, which may include agreeing a treatment plan. Remote consultations are covered where the consultant has an agreement with us to be reimbursed for these.



Please note:

The fees that we agree with consultants include any room charges. Our policies don't cover any extra fees for the use or hire of consultation rooms, and these shouldn't be passed on to Bupa patients.

All procedures have an individual code and these can be found online in our Schedule of Procedures at codes.bupa.co.uk.

Please use the search tool if you're unsure of a code and if you're still unable to find it, please call us on **0345 755 3333** and we'll be able to help. We're here between 9am and 5pm Monday to Friday. We may record or monitor phone calls.

When recommending treatment for a Bupa patient, please give them the relevant procedure code(s) and description to help them when they pre-authorise their treatment with us.

This will avoid any ambiguity for them, make it easier for you to invoice us and means that we can pay you promptly.

Follow-up consultations and procedures on the same day

Our policies cover initial consultations and procedures carried out on the same day so long as they're covered by the patient's policy. However, they don't cover follow-up consultations on the same day as most procedures.

This is because our procedure fees cover all component parts of that procedure including pre-operative assessment, the procedure itself and all routine aftercare such as inpatient follow up and outpatient consultations on the same day.

There are some exceptions where our policies will cover follow-up consultations on the same day as procedures, and these can be found in the Schedule of Procedures marked with (ii) at codes.bupa.co.uk.

Examples:

D0210 Excision of lesion of pinna

Procedure code D0210 includes all routine aftercare because it's not marked with (ii) in the Schedule of Procedures.

The procedure fee includes the initial consultation, the procedure and all routine aftercare on the same day. If the excision cannot be carried out on the same day as the initial consultation, the procedure itself will be covered separately. As the procedure fee includes all routine aftercare, a follow up consultation on the day of the procedure isn't covered.

H2502 (ii) Diagnostic flexible sigmoidoscopy (including forceps biopsy and proctoscopy)

Procedure code H2502 is marked with (ii) so a follow up consultation on the same day is covered separately because the procedure fee doesn't include all routine aftercare.



Length of hospital stays

The Schedule of Procedures (codes.bupa.co.uk) includes the maximum length of hospital stay covered for each procedure. Where a patient needs to stay in hospital for a procedure, the expected maximum length of stay is shown as a number. Inpatient, day-case and outpatient stays are shown as I/P, D/C and O/P.

Anticipated lengths of stay are also published by organisations such as the Audit Commission and the British Association of Day Surgery.

We regularly update the Schedule of Procedures so it represents best clinical practice. We look at comparable NHS information and consult with specialists to make sure our policies are clinically appropriate and that we deliver what Bupa patients expect.

We recognise that sometimes the length of stay in the Schedule of Procedures can differ from that needed by a Bupa patient with specific circumstances.

When this happens, we'll review requests to cover an extended stay. Consultants will need to send us a medical report or a completed form found at bupa.co.uk/los-extension explaining why this is needed.

Where an extended stay in hospital is clinically appropriate and covered by the patient's policy, we'll provide a pre-authorisation number.



Tip:

If your patient needs to stay in hospital longer than our pre-authorisation covers, please contact us as soon as possible so we can let you know their care is covered. This includes when day-case procedures require an overnight stay.



Surgical fee uplifts

We appreciate that our Schedule of Procedures may not address every medical situation. Consultants can request a surgical fee uplift where:

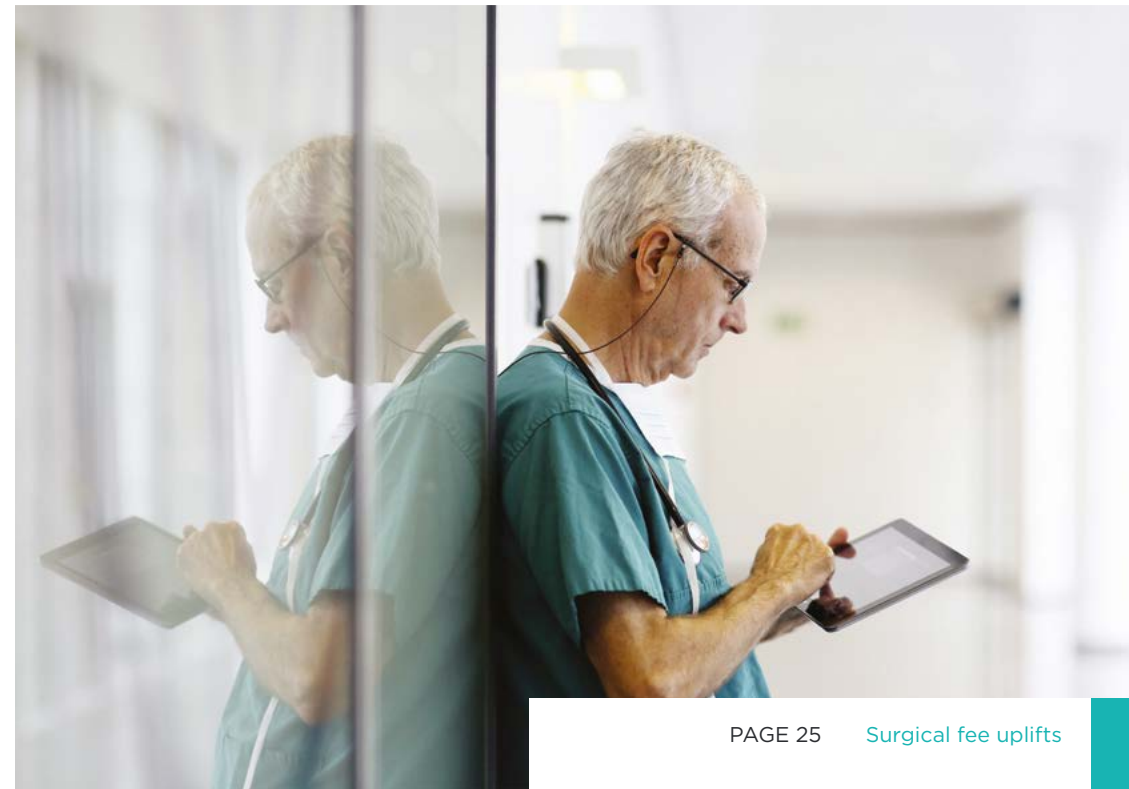
- a procedure is more complex (and may take significantly longer) than indicated in the Schedule of Procedures; or
- more than one consultant operates on a patient during the same theatre session (known as two-handed or multiple-handed surgery).

Fee uplifts may be requested either:

- **pre-operation** which means estimating the duration and complexity of the procedure; or
- **post-operation** with all the details about the operation or treatment that has taken place.

Consultants need to follow the steps in note 8.4 of the Essential Notes in the Schedule of Procedures (codes.bupa.co.uk) and send us the relevant information.

We review all requests to see whether the patient's policy covers a higher fee.





Invoicing

We'll cover the cost of consultations, tests and treatments carried out by Bupa recognised healthcare professionals so long as these are covered by our customers' policies. We know how important the prompt payment of invoices is to the efficient running of your practice and we want to support you in this. That's why we ask you to invoice us electronically. This is an easy way to make sure invoices reach us and are paid promptly.

Invoicing electronically is:

quicker - you know immediately that we've received your invoice and it contains all the information we need to pay you on time.

safer - sensitive patient information is secure and can only be seen by people who need to see it to process your invoice.

cheaper and better for the environment - not only does it save you money on stationery and postage, but it's good for the environment too.

Providers Online website

bupa.co.uk/providers-online

You can also use our website to bill us, view your pre-authorisations, pre-populate invoices, track the progress of your accounts and see when we'll pay your invoices.

You can also:

- Send all your Bupa invoices to us securely online for faster payment.
- View the status of your invoices and pre-authorisations.
- Download your statements at any time.
- Update your correspondence and statement addresses and bank account details so there's no need to call or write to us with any changes.

- Access online information to help you such as the Schedule of Procedures and the maximum reimbursement for surgeons' and anaesthetists' fees (Bupa Benefit Maxima).
- Give members of your practice team access to your Providers Online account so that they can manage it on your behalf.
- Update your Finder profile. Finder is our online directory of Bupa recognised healthcare professionals and services used by tens of thousands of people every week.

Information we need to pay you quickly:

- Your patient's full name, date of birth and Bupa membership number.
- Your Bupa provider number, which is your General Medical Council number with a 'O' at the start.
- The relevant procedure code(s) which can be found at: codes.bupa.co.uk.

Other electronic billing options:

You can find out more about other ways to bill us online at:

bupa.co.uk/healthcare-professionals/billing-and-payment.

Or you can pay a billing service provider to convert your paper invoices into electronic ones. Find out more at: bupa.co.uk/healthcare-professionals/billing-and-payment/how-to-bill-bupa.





Consultant recognition

Our health insurance patients must see a Bupa recognised consultant for any treatment to be covered by their policies. Recognised consultants meet specific criteria including:

- registration with the General Medical Council (specialist register)
- hold (or have held) a substantive NHS consultant post
- have professional indemnity cover
- have direct admitting rights to a Bupa recognised hospital or clinic
- accept direct payment from Bupa by BACS.

We work with around 20,000 Bupa recognised consultants who provide high quality good value treatment and care to our customers.

The majority of these consultants have agreed consultation fees with us, offer tests and treatment to Bupa patients in line with the fees in our Schedule of Procedures and don't send bills to patients for additional fees. We call these consultants fee-assured. They give certainty that patients won't face any unexpected bills for their care.

There are occasions when we need to suspend or remove a consultant's recognition. This happens very rarely. For example, where consultants charge above prices agreed in their contract and we're unable to reach mutual agreement, it may affect their Bupa recognition.

For clinical matters, we base our policy for suspension and or removal of a consultant's recognition on General Medical Council (GMC) licensing and standards and British Medical Association (BMA) guidance.

For example, where a consultant doesn't have or loses their GMC licence to practise, or has conditions imposed on it, or if they lose their practising privileges at any NHS or private hospital we may suspend or remove their Bupa recognition.

Therapist recognition

We work with over 10,000 Bupa recognised therapists across a range of specialities. All our recognised therapists are part of a network of specialist services, either individually or as part of their practice in the case of physiotherapists.

When Bupa patients need to see a therapist, we offer them a choice from the appropriate specialist network.



Hospital recognition and networks

Our health insurance policies cover treatment by Bupa recognised healthcare professionals at hospitals and clinics within the patients' chosen hospital network.

A recognised hospital or clinic is one that meets specific criteria, including registration with the Care Quality Commission (CQC) and offering the services we cover at agreed prices in a contract called a Healthcare Services Agreement (HSA).

Bupa offers patients a range of hospital networks. For example, depending on where they live, they may choose a smaller network or to exclude central London hospitals if they're looking to reduce their premium.

We also have hospital networks set up to deliver specific services covered by our health insurance policies, for example cataract treatment, MRI and CT scans. Hospitals need to meet quality standards for the services to belong to these networks. The agreements we have with hospitals and clinics offering these services are separate to the main HSA.

Treatment outside of a patient's chosen hospital network

Sometimes a patient needs treatment that isn't available within their chosen hospital network. When this happens, we need to understand the clinical rationale for this before we can agree to cover an 'out of network' request for treatment.

We can only cover treatment at a Bupa recognised hospital or clinic, or at those where we've agreed prices for 'out of network' treatment.

Contact information

Hospitals and clinics

Information about new requests for recognition:

bupa.co.uk/healthcare-professionals/for-your-role/facility/facility-recognition

Consultants

Apply for Bupa recognition online:

bupa.co.uk/healthcare-professionals/for-your-role/consultants/consultant-recognition

Therapists

Apply to become a Bupa recognised therapist:

bupa.co.uk/healthcare-professionals/for-your-role/therapists

Other types of healthcare professional

If you'd like further information about our range of healthcare services or find out more about working with us, follow this link:

bupa.co.uk/healthcare-professionals/for-your-role

Call 0345 755 3333
for information on all other Bupa services.

Lines are open 9am-5pm Monday to Friday.

We may record or monitor phone calls.

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