High dependency or intensive therapy unit stays

Funding request form

Please complete this form to request Bupa funding for a patient to stay in a high dependency unit (HDU) or intensive therapy unit (ITU).

Our customers' health insurance schemes may cover the cost of a HDU or ITU stay if the patient meets Intensive Care Society (ICS) criteria for Level 2 and Level 3 care. 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.

Please return the form to us by secure email to **caresupportteam@bupa.com**

Information you send us by email isn't usually secure until it reaches us. We use secure email provided by Egress Switch. You can sign up for a free account at **https://switch.egress.com**. You won't be charged to send secure emails to a Bupa email address using this service.

If you've any questions please call the Bupa Care Support Team on **0345 266 9685**, we're here between 8am to 6pm Monday to Friday. We may record or monitor our calls.

1. Patient and hospital information

Patient's name

Bupa membership number

Date of birth D D M M Y Y Y Y

Hospital contact name

Hospital contact telephone number

Does the patient meet the ICS eligibility criteria for care[1]? ☐ Yes ☐ No

Was the patient transferred into this Level 2/3 unit for eligible private treatment following at least 24 hours Level 0/1 care? ☐ Yes ☐ No

Number of nights requested

Was the patient on a private ward for 24 hours before transfer to ITU/HDU? ☐ Yes ☐ No

Reason for admission to ITU/HDU

1 Levels of critical care for adult patients. Intensive Care Society.

2. Clinical information

	Day 1	Day 2	Day 3	Day 4	Day 5
Date					
Level of care					
HDU Level 2	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ITU Level 3	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Respiratory care					
Ventilated	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation type/mode					
Oxygen					
Litre/Min (%)					
SPO2% Range					
Respiratory rate					
ABG abnormalities and lactate					
Cardiovascular					
Heart rate and rhythm					
Blood Pressure Range					
Inotropes (State)					
Invasive monitoring CVP reading					
Arterial Line in situ	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Clinical information continued

	Day 1	Day 2	Day 3	Day 4	Day 5
Date					
Renal monitoring					
Urine output (mls/hour)					
Haemofiltration	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dialysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Electrolytes					
Urea					
Creatine					
K+					
CRP					
Blood transfusion					
Blood transfusion	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Units					
HB					
Neurological sedation					
Neurological sedation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Glasgow Coma Score					
Analgesia					
Epidural thoracic					
Epidural lumbar					
Block					
PCA					
Other, please detail					
Form completed by					
Name					
Nurse PIN					

3. 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

Date completed D D M M Y Y Y Y

General Medical Council number

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