



Retrospective funding request form

Please complete this form to request funding for a “follow on” PCI procedure after a query proceed angiogram in Bupa patients with stable coronary artery disease.

If the patient has stable coronary artery disease and doesn't need an emergency PCI procedure, please make sure that all diagnostic tests are complete and a definitive decision has been made to proceed to PCI then complete a Funding request form: Percutaneous coronary intervention (PCI) instead.

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 that the procedure is covered by their health insurance policy. Otherwise we'll let you know within two working days of receiving your completed form whether the Bupa patient's treatment is covered.

Please type this form and complete all sections. Without all the information, 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. To sign up for a free Egress account, go to <https://switch.egress.com>

If you've any questions please call us on: **0345 600 7264** (between 8am to 8pm Monday to Friday, and 8am to 4pm Saturday) or: **0345 755 3333** (between 8am to 6pm Monday to Friday, and 8am to 1pm Saturday). We may record or monitor our calls.

1. About the patient

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

Name

Date of birth

Bupa membership number

Admission hospital

Date of procedure

Code for procedure

2. About the consultant

Name

Bupa provider number

Phone number

3. About the patient's condition

Were the patient's symptoms stable?

Yes No Asymptomatic

If no, please explain the patient's condition

Has the patient had a previous:

Coronary artery bypass graft (CABG) Yes No

If yes, please give date of procedure

Name of consultant who performed it

Elective PCI for stable Coronary artery disease (CAD) Yes No

If yes, please give date of procedure

Name of consultant who performed it

Primary PCI for Coronary artery disease (ACS) Yes No

If yes, please give date of procedure

Name of consultant who performed it

Was medical therapy optimised? Yes No

If no, please provide rationale below

Was a functional test performed? Yes No

If yes, please tick all that apply

- Exercise (electrocardiogram) ECG Stress echocardiogram
 Myocardial perfusion scan Stress (magnetic resonance imaging) MRI
 Other, please state:

Did the functional test demonstrate evidence of inducible ischaemia? Yes No

What was the total approximate percentage ischaemic burden?

Was a Fractional Flow Reserve (FFR) performed (either invasive FFR or CT FFR)?

Yes, if so was it an Invasive FFR CT FFR

Please specify the FFR ratio

No Yes No

Was an Instantaneous Wave-free Ratio (IFR) performed?

If yes, please specify the IFR ratio

If neither functional testing nor FFR or IFR were performed, please explain why

Was this a planned staged PCI of a non-culprit lesion following a primary PCI? Yes No

3. About the patient's condition (continued)

If the patient has bifurcation lesion, triple vessel disease or left main stem (LMS) lesion, was the management of their care discussed during a minuted multidisciplinary team meeting that included a cardiothoracic surgeon?

Yes No

Name of cardiothoracic surgeon

Patient does not have bifurcation lesion, LMS or triple vessel disease

Please provide the type of stent used

BMS DES Bioabsorbable

Other, please describe

Make/Model no

Our policies don't usually cover biodegradable/bioresorbable stents. If one has been used, please give the clinical rationale.

Please give any other relevant information, including the proposed treatment plan.

4. Declaration

Please complete this section to confirm that the information in this form is accurate to the best of your knowledge.

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

General Medical Council number

Date