Spinal fusion surgery

Funding request form

Please complete this form to request funding for Bupa patients who need spinal fusion surgery. We fund treatment covered by the patient's policy that's in line with published evidence-based guidelines.

Please complete each section of this form, as it captures all the information we need to see whether the proposed treatment is covered by the patient's health insurance. We're unable to confirm whether treatment is covered based on incomplete forms or evidence, and we'll need to ask for more information which is likely to delay our response and the patient's treatment.

Please return this form to us by secure email to: backcareteam@bupa.com

Information you send us by email isn't usually secure until it reaches us. We use secure email provided by Egress. 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 us on: **0345 600 8277** between 8am to 8pm, Monday to Friday, and 8am to 4pm Saturday (we may record or monitor our calls).

1. About the patient

Patient's name

Bupa membership number

Date of birth D D M M Y Y Y Y

2. About the consultant

Name of consultant

Bupa provider number

Name of hospital

Name of anaesthetist

3. Details of the patient's condition and proposed treatment

Please give details of the patient's diagnosis and history of the condition (including the ICD10 code):

3. Details of the patient's condition and proposed treatment (continued)

Please give details of the proposed surgical procedure including the number of levels and the CCSD code(s)

Will the patient need a bone graft?	☐ Yes	☐ No
Will the patient's own bone be used?	☐ Yes	☐ No

Where a synthetic bone graft is proposed, please give the name and manufacturer of the graft

Please give details of your clinical rationale for using a synthetic, as opposed to an autologous, bone grafting

Have imaging tests been carried out for the patient?	☐ Yes (please give details below)	☐ No

Details of tests carried out

Have either of the following been carried out?	☐ Physiotherapy	☐ Injections

If you've ticked either, please give details below

Proposed date of surgery D D M M Y Y Y Y

4. 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 before I submitted this form.

Consultant's name

Date D D M M Y Y Y Y

General Medical Council number