Further treatment for a mental health condition

Funding request form

Please complete this form to request funding for all Bupa patients who need more treatment for a mental health condition than we've initially pre-authorised. It will mean we have all the information we need to see whether the patient's health insurance covers any further treatment.

We recommend that you submit this form as soon as you know that the patient needs more treatment than we've pre-authorised to avoid delaying future treatment. We'll let the patient know and update the number of sessions on Providers Online within three working days of receiving your completed form.

Please send us your completed form by secure email to: mentalhealthteam@bupa.com

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress Switch. For more information and to sign up for a free Egress Switch account, go to **https://switch.egress.com**. You won't be charged for sending secure emails to a Bupa email address using the Switch service.

If you've any questions, please call us on **0345 600 5446** between 8am and 8pm Monday to Friday, and 8am and 4pm on Saturdays (we may record or monitor our calls).

1. Patient information

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

Patient's name

Date of birth D D M M Y Y Y Y

Bupa membership number

Postcode

2. Therapist information

Therapist's/Consultant's name

Bupa provider number

Email address

3. Diagnosis

Please give details of the patient's diagnosis / working diagnosis/ presenting symptoms and the date of onset for all conditions being treated (consultants, please include ICD codes):

4. Outcome measures

Please give details of any outcome measure tools you've used, for example PHQ9, GAD7, BDI etc, and include the results with dates:

Date	Measure	Score/Outcome

5. Treatment

How many sessions has the patient had to date?

What was the last treatment date? D D M M Y Y Y Y

How many additional sessions are being requested?

Please summarise the treatment plan going forward including relapse prevention and recovery targets:

Please give the following details:

- the clinical rationale and other factors influencing treatment progression
- relevant evidence to support the additional treatment request
- any risk assessment (please send a copy if relevant)

5. Treatment (continued)

Please list all relevant medication patient is currently taking, including frequency and dosage:

6. Declaration

Please complete the section below to confirm that the information in this form is accurate to the best of your knowledge. We may request a copy of the patient's full medical notes from you and their GP to confirm that the proposed treatment is covered by their health insurance.

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.

Therapist's/Consultant's name

Date completed D D M M Y Y Y Y

General Medical Council number (if completed by a consultant)