Spinal stenosis surgery

Funding request form

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

Please fill out 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, along with the GP referral letter and any clinic letters relating to this condition, 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

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

2. About the consultant

Consultant's name

Bupa provider number

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

Diagnosis and history of the condition, including the ICD10 code

Surgical procedure being requested and number of levels

Description:

CCSD code(s):

Number of levels that need surgery and proposed procedure at each level:

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

Indication for surgery

Proposed date of surgery

Have imaging tests been carried out for the patient? ☐ Yes ☐ No

If yes, please give details

Please give details of previous treatment for this condition, including any medications or non-surgical treatments

Please give details of contraindications to conservative treatment

Have any alternative treatment options been discussed/considered with the patient? ☐ Yes ☐ No

If yes, why were these not suitable?

If your patient has elected to have surgery, have they taken part in shared decision making? ☐ Yes ☐ No

4. 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