Request for eligibility of treatment

Patient's details:

Full name: ______________________________

Date of birth: ______________________________

Insurance number: ______________________________

Provider details:

Hospital name: ______________________ Country: ______________________

Name of specialist in charge: ______________________________

Name of contact point for enquiries: ______________ Email: ______________________

Fax number: ______________________ Tele number: ______________________

Medical information:

Symptoms: ______________________ Diagnosis: ______________________

______________________ ______________________

______________________ ______________________

Vital signs: BP______________ Pulse______________ Temp______________ RRate______________

ICD code: ______________________________

Date when symptoms for this condition were first noticed by patient: ______________________

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When was this condition first diagnosed? ______________________________

Treatment details: ______________________________

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Details of patient's regular medication: ______________________________

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Previous related treatment history: ______________________________

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Date of admission: ______________________________

Expected date of discharge: ______________________________

Estimated hospital charges: ______________________ Estimated physician charges: ______________________

Signed: ______________________ Position: ______________________

Please ensure this information is provided 24 hours prior to admission.
Failure to complete this information in full could delay our ability to provide a decision.

Bupa

Return this document to the following:

Email: pre-authorisation@bupa-intl.com or fax: 0044 1273 866301