Important points about your Bupa patients’ cover
We’ve created this booklet to help explain some important points about your Bupa patients’ cover. It’ll give you an overview of the standard features and benefits included in their health insurance cover.

Health insurance, like other insurance policies, provides cover for unexpected events happening after the start of the policy. In health insurance this means cover for the cost of unforeseen private medical treatment.
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Our health insurance schemes

The schemes chosen by your Bupa patients can differ in many ways, including levels of cover, cancer cover options and out-patient limits. Here are some of these options explained.
Excess/Co-insurance

Some schemes have a voluntary excess option as a way of lowering the health insurance premium the patient has to pay. The higher the excess they choose, the lower the premium will be. An excess is paid, up to the chosen excess amount, once per person per policy year regardless of how many claims the patient makes in that year. Where treatment spans a patient’s scheme renewal date, in most cases they’ll need to pay the excess again. This means the patient would need to pay their excess twice in quick succession.

There’s also a co-insurance option which works similarly to an excess (sometimes referred to as co-pay). It means that the patient pays a set proportion of each claim for treatment up to a maximum co-pay amount in a policy year and we pay the rest (up to the agreed benefit limits). Unlike an excess, it’s paid for each claim, per person, per policy year.

Please note:

the excess or co-insurance is paid directly to you and not to us. We’ll write to your Bupa patient to let them know who they should pay the excess or co-insurance to, for example, their consultant, therapist or recognised hospital or clinic.

Selection of hospital networks

We offer different types of hospital access, and all the hospitals are quality assessed in the UK. People can select a scheme with a restricted list of hospitals as a way of lowering the cost of cover. For example they can opt for a list that either includes or excludes central London hospitals where treatment is usually more expensive than others. Similarly, they can opt for a more comprehensive list of hospitals for a slightly higher premium if they prefer. You can find further information about our network hospitals on page 29.

Out-patient benefit limits

Many patients’ schemes cover all stages of treatment, however some may choose to add an ‘out-patient limit’. In most cases, they choose an allowance out of which all out-patient consultations, minor diagnostic tests and out-patient treatments (which aren’t classified as a surgical procedure) and therapies are paid for the year. If they use up this allowance, they need to pay for any out-patient claims beyond this point.

This option isn’t available on all schemes. Some lower-cost option schemes don’t cover any out-patient charges, including diagnostics, unless they follow in-patient treatment covered by the patient’s scheme. Treatment is only covered as long as the patient is seeing a recognised healthcare professional at a recognised hospital or clinic in the hospital network they’ve chosen for their scheme.
Underwriting

Underwriting for health insurance is the way we decide the terms on which we’ll cover a person based on the information they give us about their medical history. We usually offer a choice of two main options: Full Medical underwriting and Moratorium underwriting. There may be other choices available depending upon the scheme chosen, or if a person has previously had health insurance with another insurer. Our two main options are explained below:

- **Full Medical underwriting** means that the person’s medical history is taken into account when deciding which medical conditions we may or may not be able to cover when they join. We usually don’t cover them for conditions they experienced before they take out insurance with us. These are known as ‘pre-existing conditions’ or ‘special conditions’. People generally choose full medical underwriting so they know exactly what they’re covered for. With full medical underwriting, new medical conditions that begin after the start of the policy will be covered, subject to the policy terms and conditions.

- **Moratorium underwriting** means that the person doesn’t need to declare their medical history when they join. If they’ve had a medical condition before joining us, then it wouldn’t be covered for at least the first two years of their policy. The time period used to determine whether a condition is pre-existing can vary between two to five years depending on the scheme chosen.

People who choose this underwriting option will need to complete a pre-treatment form each time they claim so that we can confirm whether the condition they’re claiming for is new or pre-existing.

After the first two years of joining their Bupa scheme, cover may be available for a pre-existing condition. This will depend on the person not experiencing any symptoms, receiving any treatment or seeking medical advice about the condition for a full two years after joining us. We may be able to fund their future treatment for a pre-existing condition provided it’s covered by their policy.
Health insurance schemes also include general exclusions (things that aren’t covered by health insurance) to help us keep premiums affordable.

Examples include:
- the maintenance of chronic conditions
- the natural ageing process
- treatment of allergies
- cosmetic surgery
- pregnancy.

Your patients can check what’s excluded from their cover by reviewing their policy guides, we publish a full list of general exclusions in them.
How does your patients’ cover work?

Our health insurance is designed to give your Bupa patients fast access to private treatment for acute conditions that are covered by their policy and start after their cover begins (subject to their underwriting terms, as explained earlier).

It covers the cost of medically necessary, planned private consultations, tests and treatment for acute conditions.

An acute condition is a disease, illness or injury that’s expected to respond quickly to treatment which aims to return the patient to their previous state of health.

Chronic conditions

Like most other health insurers, our health insurance schemes don’t cover the treatment of chronic conditions. We use the Association of British Insurers (ABI’s) definition of chronic conditions. This is:

**A disease, illness or injury which has one or more of the following characteristics:**
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.
What does this mean in practice?

Chronic or long term illnesses can often require reoccurring consultations over a long period, checks on medication, and/or long term therapy or treatment usually needed to keep a condition or its symptoms under control. Our health insurance doesn’t cover treatment that’s needed as part of the ongoing management of care because these symptoms are part of the natural progression of the disease.

What’s covered?

Your Bupa patients are generally covered for specialist consultations until they’re diagnosed with a chronic condition, then they’ll need to go back to the care of their GP and the NHS for the ongoing management, screening and monitoring of the condition. Alternatively, they may choose to pay for private treatment with you yourselves or through using our self-pay services.

If your Bupa patient experiences a sudden unexpected deterioration in their condition, also known as an acute flare-up, we’ll fund a short course of treatment that can modify or cure the symptoms so long as it’s covered by their policy. We cover treatment of an acute flare-up when the condition is likely to respond quickly and the treatment aims to restore the patient to their state of health immediately before suffering the acute flare-up. After this, the patient would need to return to the NHS for the ongoing management of their condition or they may decide to pay for private treatment themselves.

In most cases health insurance doesn’t cover emergency treatment, so if urgent medical attention is needed to help stabilise or treat a Bupa patient’s condition, they should use NHS emergency services in the normal way. However once the patient’s condition has stabilised and if their consultant agrees that they’re well enough, they may be able to transfer to private care for any planned treatment needed so long as their condition and the treatment are both covered by their policy.
Transfer of private patients to the NHS

Health insurance is intended to complement the NHS. Patients may need to return to the NHS if treatment for their condition is no longer covered by their policy, or pay for it themselves if they'd prefer to continue privately.

Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient. However a patient can’t be both a private and an NHS patient for the treatment of the same condition during a single visit to the NHS.

Once it’s established that the patient’s treatment is no longer covered by their policy, the consultant treating them should ensure they’re able to seek appropriate treatment and care in the NHS. Patients referred for an NHS service after a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service.

An example of how our cover works

The following fictional example is designed to show how our schemes work. Please bear in mind that, where we say a treatment or consultation isn’t covered by a patient’s health insurance, it’s usually due to the general exclusions that apply to their policy – it doesn’t mean that their treatment or consultation is not medically necessary.

**Aaron**

Aaron has been with Bupa for many years. He develops chest pains and is referred by his GP to a consultant. After consultation and investigations, he is diagnosed with a heart condition called angina. Aaron receives treatment which controls his symptoms.

Will Aaron be covered?

Aaron’s Bupa health insurance gives him access to a private consultant for consultations and initial investigations into his condition, which are normally covered by his policy. After diagnosis and any eligible treatment needed to treat his acute symptoms, Aaron will be referred back to the NHS to receive further medication and ongoing check-ups that he may need to monitor his condition.

What if Aaron’s condition gets worse?

Two years later Aaron’s chest pain returns so he visits his GP for assessment who refers him back to a consultant. The consultant recommends that he has a heart by-pass operation.

Aaron would need to call us with a new GP referral so we can pre-authorise his appointment with the consultant. We would cover the heart by-pass operation and any follow-up consultations to check how Aaron is doing after the operation for as long as they are covered by his policy. If he needs further monitoring such as six monthly check-ups, this would not be covered under his policy, but will be provided by the NHS or he may choose to pay for this himself.
Is emergency treatment covered?

Our health insurance schemes don’t cover treatment a patient receives in Accident and Emergency departments or walk-in centres (either NHS or private centres). If a patient needs emergency treatment, they should visit their local NHS emergency services in the usual way, or if they wanted to go to an equivalent private care service they’d need to pay for it themselves. Having health insurance doesn’t affect a patient’s right to use the NHS.

If one of your Bupa patients is admitted directly to a private hospital or clinic for emergency treatment, they may have to pay any costs themselves unless their policy specifically includes cover for direct admission into private emergency and urgent care.

If the patient’s policy doesn’t include cover for private emergency care and they still need further hospital treatment after an emergency admission, they may be able to transfer their care to Bupa funded private treatment. This is provided that:

- the consultant in overall charge of their treatment has agreed that they’re well enough to transfer their care; and
- the consultant receiving them is Bupa recognised and accepts responsibility for their care at the Bupa recognised hospital or clinic; and
- we’ve confirmed to the patient or their consultant that their treatment is covered by their policy.

Does this include intensive care treatment?

Our schemes only cover intensive care if it follows on from a planned admission to a Bupa recognised hospital or clinic that’s equipped with a critical care unit where the patient has been receiving private treatment that’s covered by their policy.

Our schemes don’t cover the cost of transferring intensive care from an NHS hospital or clinic to a private one, or vice versa, unless:

- the patient has been discharged from an NHS critical care unit to an NHS general ward for more than 24 hours; and
- their consultant agrees that they’re well enough to transfer their care; and
- we’ve confirmed that their treatment is covered by their policy.

If a patient develops an unexpected complication after receiving Bupa funded private treatment in a hospital or clinic that doesn’t have its own critical care unit, we may cover their transfer to another Bupa recognised hospital or clinic for care. However this is only in exceptional circumstances, and if the two hospitals or clinics have a Bupa approved agreement in place between them.

In all other circumstances, arrangements should be made to transfer the patient to their nearest NHS ITU hospital or clinic. The transfer to the NHS ITU hospital or clinic isn’t covered by our health insurance schemes.
Tip:
You can check if intensive care is routinely covered after a planned procedure using our code search at codes.bupa.co.uk. Codes marked with an (i) mean that intensive care is routinely required after that procedure. We list the maximum number of days that we’ll routinely cover for both the general ward and ICU against the procedure.
Our cover for drugs, experimental treatment and appliances

Our health insurance gives patients access to innovative drugs, treatments and therapies as long as they’re covered by their policy. However, there are circumstances where some drugs aren’t covered by our schemes to help keep health insurance affordable.

Take home medication and separately chargeable drugs

Drugs prescribed for out-patient treatment, or for taking home when the patient leaves hospital aren’t covered by our schemes. Patients need to pay for drugs they receive as part of their out-patient treatment themselves unless the treatment is licensed to treat cancer, when the hospital can charge us separately for them.

We fund the drugs patients receive as part of their in-patient stay unless these drugs aren’t covered by the specific terms of their policy (see the section ‘Drug treatment of chronic or special conditions’). Usually the cost of in-patient drugs is included in the package price we pay the hospital for all the services the patient receives there. We have agreements with most hospitals to give Bupa patients a few days’ worth of drugs so that they can go home and get the remainder of their treatment from their GP.

However, some specialist drugs can be expensive so we have a list of drugs that are charged separately from these packages, and hospitals should obtain pre-authorisation from us before they’re given to a Bupa patient. Details of these drugs can be found on the Separately Chargeable Drugs List (SCDL) at www.bupa.co.uk/separately-chargeable-drugs.
Drug treatment of chronic or special conditions

Our schemes don’t cover drugs that are given to patients as part of procedures not covered by their policy, or those used to treat chronic conditions. Some Bupa patients may also have specific pre-existing medical conditions excluded from their cover and we wouldn’t cover any treatment, drug or any other medical intervention linked to those conditions.

Experimental/unproven/out of licence treatment

Our schemes don’t cover treatment or procedures which, in our reasonable opinion, are experimental or unproved by established medical practice in the UK. This includes drugs outside the terms of their licence or procedures which haven’t been satisfactorily reviewed by NICE. In some instances, we make exceptions to fund this type of treatment for acute conditions on a discretionary basis but the patient will need our written agreement before having the treatment.
Out of licence drugs

We may cover the cost of some cancer drugs that aren’t licensed or drugs that we don’t routinely fund in the UK upon request from the patient’s consultant. When assessing these funding requests, we look at the strength and quality of the evidence of clinical effectiveness and the anticipated measurable outcomes. These outcomes may include improvements in overall survival, progression-free survival, clinical response, and adverse effects.

When we’re asked to consider funding for an out of licence drug, we’ll ask you to complete a form which captures all the information we need to assess whether the patient’s health insurance policy can cover it. Please give us all the requested information and allow a reasonable time before treatment begins so we’re able to make a funding decision without causing any delays to the patient’s treatment.

We’ll let you know whether the proposed treatment is covered by the patient’s policy within three working days of receiving your completed form.

Prosthesis and appliances

We wouldn’t normally pay extra for any appliance that a patient is expected to take home after a procedure such as a plaster cast, or any high cost consumable such as a surgical mesh that’s needed in order to perform a procedure. That’s because these items are included in the hospital charges so shouldn’t be billed separately.

However, in exceptional cases we cover the cost of some appliances or prosthesis where they are essential and an integral part of the surgical procedure which, without them, won’t work. We review these instances on an individual basis, and have an approved list of prostheses and appliances that we’ll cover separately. You can find this in our Schedule of Procedures, under ‘prosthesis and appliances’ [https://www.bupa.co.uk/~/media/Files/HCP/Latest-Updates-from-Bupa/Schedule-of-Codes/prosthesis-and-appliances](https://www.bupa.co.uk/~/media/Files/HCP/Latest-Updates-from-Bupa/Schedule-of-Codes/prosthesis-and-appliances).

Some Bupa recognised hospitals and clinics may have slightly different rules on appliances and high cost consumables in their contract with us so we recommend you check if in any doubt.
Pre-authorisation and getting referred

If a Bupa patient wants to use their health insurance to see a healthcare professional, they normally need to see their GP for a referral. However, there are certain conditions, such as cancer, that they can call us about without having seen their GP initially and we call this our Direct Access service. The list of conditions covered by the Direct Access service is updated from time to time and can be found at bupa.co.uk/direct-access.

If the Direct Access service isn’t available on the patient’s scheme and they need to see their GP for a referral, they should ask for an ‘open referral’. This means that the patient’s GP decides the type of consultant (e.g. orthopaedic surgeon or gynaecologist) they need to see for tests and/or treatment. Unless the referral is for someone aged under 16, then a GP will need to recommend a paediatrician by name.

When the patient calls us to arrange their consultation or treatment, we use the information from their GP to offer them a choice of up to three Bupa recognised consultants with the appropriate medical skills and expertise who are covered by their policy. We’ll also confirm their policy benefits available and give them a pre-authorisation number so the healthcare professional they see can bill us.

The consultants we’ll offer the patient are in our Open Referral Network, which means they demonstrate high quality of care, provide good value healthcare and great customer experience of consultants in their specialty. Before they decide who to see, patients can look up all the consultants we offer them on Finder, our online directory of Bupa recognised healthcare professionals and healthcare services.

finder.bupa.co.uk
When we ask for information
We recognise that each person’s medical treatment is different, so we work hard to treat everyone fairly. This means applying the terms of Bupa patients’ policies consistently and in doing so, we might sometimes need to ask you for information about a patient so we can confirm whether their policy covers their treatment.

If we need more information to make a decision about a patient’s treatment, we might ask you to send us a medical report or fill out one of our forms. What we ask for depends on the treatment they need. In many cases, the patient will contact you to ask for this information but if we have their permission, we might contact you on their behalf. In either instance, please make sure that your reply is suitably detailed and includes all information you think is relevant and helpful so that we can make a funding decision for the patient’s claim without delay.

Our qualified clinicians review the clinical information to make a funding decision about the patient’s proposed treatment. If we’re unable to cover the treatment, it doesn’t mean we believe that the recommended treatment is clinically inappropriate, it’s because it’s not covered by the patient’s policy. For example, we wouldn’t cover the ongoing treatment of a chronic condition but we don’t dispute this treatment may be necessary.
Consultations and procedures

We define a consultation as a meeting between a patient and their consultant to evaluate the nature and progress of a condition (disease, illness or injury) and to establish a diagnosis, prognosis and treatment plan. We expect this to be carried out on a face-to-face basis and not remotely, unless the consultant has an agreement with us to carry out remote consultations.

Please note:

Consultation fees include any room charges. We don’t pay additional fees for the use or hire of consultation rooms and wouldn’t expect these fees to be passed to Bupa patients either.
All procedures have their own procedure code, which can be found listed in our Schedule of Procedures at codes.bupa.co.uk.

When recommending treatment for a Bupa patient, please give them the procedure code and description to help them make sure that they pre-authorise the right procedure. This will avoid any ambiguity about which procedures were performed when you come to invoice us and mean that we can pay you promptly.

If you are unsure of a code, please use our code search tool available at codes.bupa.co.uk/procedures. If you’re still unable to find a code in the Schedule of Procedures, it may still be covered by our health insurance schemes. Please call us on 0345 755 3333 and we’ll be able to help. We’re here between 8am and 6pm Monday to Friday, and 8am and 1pm on Saturdays. We may record or monitor our calls.

Follow-up consultations and procedures on the same day

We’ll fund procedures carried out on the same day as an initial consultation so long as they’re covered by the patient’s policy. However, we don’t fund follow-up consultations carried out on the same day as most planned procedures. This is because the procedure fee includes all component parts of that procedure including pre-operative assessment, the procedure itself and all routine aftercare such as in-patient follow-up consultations and out-patient consultations on the same day.

There are some exceptions where we’ll fund follow-up consultations on the same day as planned procedures and these are identified in the Schedule of Procedures by (ii).

Examples:
D0210 doesn’t have (ii) under its code so it includes all routine aftercare:

D0210  Excision of lesion of pinna

If a Bupa patient needed an excision of lesion of pinna (D0210), the code would include cover for the initial consultation and the cost of the procedure. If the excision of lesion of pinna could not be carried out on the day of the initial consultation, the procedure itself would be funded separately. A follow-up consultation would not be funded on the day of the procedure as the procedure fee includes all routine aftercare.

H2502 is marked with a (ii) so you can claim for a follow-up consultation on the same day as this procedure:

H2502  Diagnostic flexible sigmoidoscopy (including forceps biopsy and proctoscopy)

If a Bupa patient needed a flexible sigmoidoscopy (H2502) and a follow-up consultation on the same day, these would both be funded separately because the procedure fee doesn’t include all routine aftercare.
Length of hospital stays

We also publish the maximum length of hospital stay covered for procedures in the Schedule of Procedures (codes.bupa.co.uk), this is shown as day-case (D/C), out-patient (O/P) or in-patient (I/P).

These are also published by organisations such as the Audit Commission and the British Association of Day Surgery. In-patient procedures show a number between 0 and 21 to indicate the maximum number of nights’ stay in hospital our schemes will cover after the procedure.

We regularly update the Schedule of Procedures to make sure that it represents best clinical practice. When carrying out updates, we look at comparable NHS information and consult with specialists to ensure our schemes are clinically appropriate and we deliver what Bupa patients expect.

We recognise that in some instances the length of stay listed in the Schedule of Procedures can differ from the length of stay needed by a Bupa patient with specific circumstances. In these instances, we’ll consider requests to fund an extended stay but we’ll need a medical report or a completed form explaining why it’s needed. Our team of specialist nurses will make a funding decision based on the information supplied and will give a pre-authorisation number where it’s clinically appropriate and the treatment is covered by the patient’s policy.
Surgical uplifts

We recognise that it’s not possible for our Schedule of Procedures to address every potential medical situation for all Bupa patients, so consultants can ask for a surgical uplift where:

- a procedure is more complex (and may take significantly longer) than specified in the Schedule of Procedures; or
- multiple consultants operate on a patient during the same theatre session (these are known as multiple-handed surgery requests).

To ask for a surgical uplift, consultants need to follow the steps set out in note 8.4 of the Essential Notes in the Schedule of Procedures (codes.bupa.co.uk) and send us the information listed.

There are three types of uplift requests:

- **Pre-operative** - estimating the duration and complexity of the procedure.
- **Two-handed/multiple-handed surgery** - where more than one surgeon operates on the patient.
- **Post-operative** - after the operation/treatment has taken place.

All uplift requests are reviewed on a case-by-case basis, using the information submitted and supporting documents (such as surgical notes and anaesthetic charts) to see whether we can offer a higher level of reimbursement.
How we respond to new treatments

Our health insurance schemes cover treatment of acute conditions together with the products and equipment used as part of the treatment.
If we receive a request to fund a new treatment or therapy, we need to check that it meets the points above and also that it’s covered by Bupa patients’ policies. For example, we wouldn’t cover treatment that’s only given to manage or temporarily relieve symptoms of a chronic condition because this is specifically excluded from our policies.

However, if the treatment aimed to provide a cure or restore a patient back to their state of health before suffering an acute illness or flare-up, then we’d fund this treatment based on the terms and conditions of the patient’s policies.

As part of a request to fund a new treatment or therapy, we’d want to know whether there’s any medical evidence available to support its use for the indicated condition or symptom, so it’d be helpful to send us any supporting information.

Once we’ve confirmed that the new treatment or therapy can be covered, we’d no longer ask for evidence before agreeing to cover that treatment for future patients, and we’d include cover for it in our health insurance schemes.

To be covered by our schemes, treatments need to be:

- consistent with generally accepted standards of medical practice,
- clinically appropriate in terms of type, frequency, extent, duration and the hospital/clinic or location where the services are provided; and
- demonstrated through scientific evidence to be effective in improving health outcomes.
Hospital recognition and networks

Bupa patients need to use recognised hospitals/clinics, therapists and consultants for any treatment or care to be covered by their policy.
A recognised hospital or clinic is one that meets specific criteria, including registration with the Care Quality Commission (CQC) and offering the services we cover at agreed prices.

Bupa patients can choose to tailor their schemes to keep their premiums down, and one of the ways they may do this is to limit the number of hospitals in the network that they have access to.

We also have dedicated hospital networks for some services that are covered by our health insurance schemes, such as MRI and CT scans, to make sure that they meet our quality standards for these services. These hospitals and clinics form part of our network of specialist services and Bupa patients have access to these through their schemes.

An ‘out of network’ request is when a Bupa patient with access to a limited number of hospitals asks for treatment in a hospital that’s not included in their chosen hospital network. Before we can agree to cover an out of network request, we’ll need a full clinical rationale explaining why the patient needs to be seen at a hospital that isn’t in their chosen network so we can give our funding decision as quickly as possible.

If the chosen hospital isn’t Bupa recognised and we’ve not agreed any out of network or out of contract treatment, we’d be unable to fund the treatment there.
Consultant recognition

Bupa patients must see a recognised consultant, for any services provided, to be covered by their policies. A recognised consultant must meet specific criteria including:

- registration with the General Medical Council (specialist register)
- holding (or have held) a substantive NHS consultant post
- have professional indemnity cover
- have direct admitting rights to a recognised hospital/clinic
- accepting direct payment by BACS

There are occasions when we need to suspend or remove a consultant’s recognition. This happens very rarely. Our policy for suspension and/or removal of a consultant’s recognition is based on GMC licensing and standards, and British Medical Association (BMA) guidance. For example, we won’t recognise consultants if they don’t have, or lose, or have conditions imposed on, their GMC licence to practise; or if they lose their practising privileges at any NHS or private hospital.

All consultants should offer services to Bupa patients at the prices they’ve agreed to in their contracts with us. If any consultant charges above prices agreed in their contract, we may have to do a full investigation, including contacting the consultant to find out why it has been charged in this way. If we can’t come to an agreement or arrangement, the consultant’s recognition may be affected.

In addition, to help give patients certainty that they won’t face any unexpected bills for their consultants’ fees, we offer them consultants who are fee assured. This means that they’ve agreed to charge within our benefit limits for surgical procedures and not to send bills to patients for additional fees.

Therapist Recognition

When Bupa patients need to see a therapist, we offer them a choice from one of our specialist networks. All our recognised therapists are part of a network of specialist services, either individually or as part of their practice for physiotherapists.

If you’d like to apply for Bupa recognition, either call us on 0345 600 5422* (we’re here between 8am – 6pm Monday to Friday) or email us at provrec@bupa.com.

*We may record or monitor our calls.
Contact information

**Hospitals and clinics**
Information about new requests for recognition:
https://www.bupa.co.uk/healthcare-professionals/for-your-role/facility/facility-recognition

**Consultants**
Apply for Bupa recognition online:
https://www.bupa.co.uk/healthcare-professionals/for-your-role/consultants/consultant-recognition

**Therapists**
Apply to become a Bupa recognised therapist:
https://www.bupa.co.uk/healthcare-professionals/for-your-role/therapists

**Other types of healthcare professional**
If you’d like further information about our range of healthcare services or find out more about working with us, follow this link:
https://www.bupa.co.uk/healthcare-professionals/for-your-role
Call 0800 600 500
for information on all other Bupa services.

Lines open 8am-8pm
Monday to Friday
8am-4pm on Saturday.

We may record or monitor our calls.

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