DRN-5962795

The complaint

Mr D has complained about the way BUPA Insurance Limited handled a claim he made on a private medical insurance policy.

What happened

Mr D was injured playing sport in April 2025. He was mistakenly told that, prior to receiving authorisation to see a consultant, he would need to get his GP to complete a History and Onset (H&O) form.

In responding to the complaint, Bupa acknowledged that it had made an error. It therefore apologised and paid Mr D £200 compensation for poor service, as well as a refund of the £30 he paid for the GP to complete the form.

Our investigator ultimately thought that Bupa had responded fairly and reasonably. Therefore, he didn't uphold the complaint. Mr D disagrees with the investigator's opinion and so the complaint has been passed to me for a decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

I've carefully considered the obligations placed on Bupa by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Bupa to handle claims promptly and fairly, and to not unreasonably decline a claim.

Mr D suffered his injury on 6 April 2025. He then rang Bupa on 7 April 2025 and it was arranged for him to speak to a virtual GP the same day. The GP apparently said they could authorise for him to see a consultant. However, they authorised for him to see a sports physiotherapist in the first instance, that being Mr D's preference. He then saw the physiotherapist on 8 April 2025. Therefore, up to that point, the claim had progressed as it should. It was after this that things went awry.

Mr D's current policy began in March 2025. He'd previously held membership via his employer's scheme. If someone in that situation makes a claim early in the life of the policy, they can be asked to complete the H&O form to check whether the referral for treatment was made before the policy began.

So, when Mr D rang Bupa again later on 8 April 2025 to say that the physiotherapist was recommending that he should see a consultant for a second opinion, the adviser mistakenly thought that an H&O form was required. However, as the referral had been made via Bupa's own direct access service the day before, it should have been abundantly clear that the referral had been made after the policy had been taken out.

Anticipating that there would be a delay in his GP completing the form, plus the five days he'd been told might be the time needed for Bupa to assess the information, he arranged to self-fund an appointment with the consultant on 10 April 2025 and an ultrasound on 11 April 2025 (having rung Bupa on 9 April 2025 to set up his bank details on his account for reimbursement).

It was when Mr D rang Bupa on 11 April 2025 that the error was uncovered. Mr D was told that he hadn't needed to get the H&O form. His claim was then authorised. So, at that point he understood that the treatment he'd had so far was covered and would be reimbursed, and that any ongoing treatment would be covered and paid directly by Bupa.

If things had happened as they should have, Mr D would have received his authorisation code on 8 April 2025, when he called to arrange to see a consultant. Instead, he received that some three days later, on 11 April 2025.

When looking at this complaint, a relevant consideration is what the consequences were for Mr D of being given the misinformation. He had to go to the trouble of visiting his GP to drop off and collect the form. He was also, quite rightly, frustrated about the way the claim was being dealt with, given his history with Bupa and the nature of his injury. He felt he was being denied treatment at a time when he was in pain. And he had to self-fund the initial consultation and scan.

However, I'm not persuaded that there was any delay to Mr D's treatment as a result of the error. Luckily, he was in a position to self-fund and arrange to see the consultant. Bupa is not responsible for him not seeing the consultant until 10 April 2025, as Mr D has said that was the earliest the consultant was available. Therefore, even if he had been given the pre-authorisation on 8 April 2025, it's unlikely that he'd have been able to see the consultant any sooner.

There weren't any issues around Mr D's treatment plan after he received authorisation on 11 April 2025. He went on to have an MRI on 14 April 2025, which was covered by Bupa.

Mr D continued to have contact with Bupa in relation to his complaint, which resulted in further dissatisfaction, such as when he didn't receive requested calls back. Bupa has again acknowledged its shortcomings in this regard and part of the £200 payment was compensation for poor complaint handling.

I've thought very carefully about what Mr D has said, especially about how he was made to feel during the time before the error was corrected. I'm very sympathetic to his situation. In addition to being in pain, he had to deal with the uncertainty of whether his treatment would be covered. Bupa's actions didn't live up to the expectations he had when taking out private medical insurance. However, as an alternative dispute resolution service, our awards are more modest than Mr D might expect, and likely less than a court might award. Overall, I'm satisfied that Bupa has acted reasonably in paying £200 compensation plus £30 for the refund of the GP fee. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint. My understanding is that BUPA Insurance Limited has already paid the £230, so I am not asking it to do anything more.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 23 December 2025.

Carole Clark
Ombudsman