# Request for Access to Protected Health Information

This form will allow me, as a CareAllies®* member/participant to request access to Private Health Information (PHI) about me that CareAllies maintains and that was created or received by CignaHealthcare during the time of my employment with the employer identified below.

## Verification – (Please Print)

**Identification of Member/Participant requesting PHI:** (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant:_____ Date of Birth: _____

Phone number where we can reach you if we need to contact you to process your request (required): _____

Social Security # (Optional): _____ Member/Participant ID card # (if applicable): _____

Group or Account # on ID card: _____ Subscriber Name (if different from Member/Participant): _____

Subscriber's Relationship to Member/Participant: _____ Subscriber's Employer Name: _____

Subscriber's Social Security # (if different from Member/Participant) (Optional): _____

**If you have additional coverage with CareAllies, other than described above, please complete the following information as well:**

Other Employer Name: _____

1. Member/Participant ID card #: _____ Group or Account # on ID card: _____

## Request

Address for CareAllies to send requested information:

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Information Requested from Records Maintained by CareAllies

☐ Adjudicated (processed) claims: This is a summary of claims paid or denied.
*(This does not include information on claims received but not yet processed – if you would like the status of those claims you may call Member Services at the toll free number listed on your or the Subscriber's CareAllies ID card.)*

☐ Enrollment or eligibility information that CareAllies has received from the Subscriber's employer or from the Subscriber/Member/Participant.
*(This includes information such as name, address, phone number, SSN etc.)*

☐ Case management and medical utilization management information (CM/MM).

☐ Other information *(please describe)*: _____

_____

Type of Information Requested:

☐ I request the information checked above for my CareAllies Medical benefits.

☐ I request the information checked above for my Evernorth Behavioral Health benefits.
*(Please make sure you have coverage through Evernorth Behavioral Health before you request this information.)*

☐ I request the information checked above for my Cigna Dental benefits.
*(Please make sure you have coverage through Cigna Dental before you request this information.)*

**Most information is maintained and will be provided for a 24 month period. It may not be possible to provide information beyond that period. There may be other PHI created or maintained by the Subscriber's employer/Group Health Plan and/or its business associates and not included in this response for access. You should contact the employer to obtain any additional information.**

CareAllies®



*Please Complete Next Page ↪*

## Please Note

- *If the information on this form is not complete, CareAllies will return the form to you, and this request will not be considered until CareAllies receives complete information.*
- *You may not be entitled to receive all of your PHI, and will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.*

## Signature

I have read and understand the above information: Date: _____

Signature of Member/Participant, Parent/Guardian, Personal Representative if available: _____

Relationship if signed by other than Member/Participant: _____

Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member/Participant is a minor __ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please Return This Completed Form To:

CareAllies • PRIVACY OFFICE HIPAA UNIT • PO Box 188014 • Chattanooga TN 37422
Fax: 877.815.4827 or 859.410.2419