

# REQUEST TO AMEND PROTECTED HEALTH INFORMATION



This form will allow me to request an amendment of my Protected Health Information (PHI) that Cigna Healthcare maintains.

## VERIFICATION – (Please print)

### Identification of customer:

(The following information is needed for verification. Please complete all applicable items.)

Name of customer: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Address: \_\_\_\_\_

Medicare ID #: \_\_\_\_\_ Customer ID card # (if applicable): \_\_\_\_\_

## INFORMATION REQUESTED TO BE AMENDED

If Cigna Healthcare was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. If the originator consents to amend your information and notifies Cigna Healthcare, we will change the information in our records. In that case, it would not be necessary to submit this form.

If Cigna Healthcare approves your request to amend, the amended information will be used and included in all future disclosures, including correspondence. We will provide the amendment to persons who previously received the information if we believe they have relied or will rely on that information to your detriment. Also, we will provide the amendment to individuals/organizations you identify below.

Names/addresses of individuals/organizations to whom you request amended information be sent, if request is approved:

\_\_\_\_\_  
\_\_\_\_\_

Describe the Protected Health Information (PHI) you would like amended: \_\_\_\_\_

Specify change/amendment requested: \_\_\_\_\_

Date(s) of service associated with the PHI (if applicable): \_\_\_\_\_

Reason for requested amendment: \_\_\_\_\_

**Please complete the other side.**

**PLEASE NOTE**

- This amendment of your protected health information only includes information that Cigna Healthcare maintains.
- Your request may be denied. If it is denied, you will be notified in writing within 60 days. The denial will include instructions on how you can submit a written statement disagreeing with the denial.
- If the information on this form is not complete, Cigna Healthcare will return the form to you, and this request will not be considered until Cigna Healthcare has received complete information.

**SIGNATURE**

I have read and understand the above information. Date: \_\_\_\_\_

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

\_\_\_\_\_

Relationship, if signed by other than customer: \_\_\_\_\_

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If customer is unable to give consent because of age, complete the following:

Customer 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.

**COMPLETED FORM MAILING ADDRESSES**

Please send your completed form to your plan’s corresponding address below:

**Cigna Medicare Advantage Plan**

Cigna Healthcare Privacy Office  
PO Box 188014  
Chattanooga, TN 37422

**Cigna Medicare Prescription Drug Plan**

Cigna Healthcare  
PO Box 269005  
Weston, FL 33326-9927

**Please maintain a copy of this form for your records.**

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