REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION AND DIAGNOSIS TREATMENT CODE

This form will allow me, as a Cigna Member/Participant, including Behavioral Health, to request access to Protected Health Information (PHI) about me that Cigna maintains and that was created or received by Cigna during the time of my employment with the employer identified below. This form may also be used to request additional information about diagnosis and treatment codes.

1. 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**: _____
Address on Record (required): _____
Phone number where we can reach you if we need to contact you to process your request (required): _____
Last 4 Social Security # (Optional): _____**Member/Participant ID card #** (if applicable):_____
Group or Account # on ID Card: _____ **Subscriber's Employer Name**:_____

_____

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

Other Employer Name: _____
Member/Participant ID Card #: _____**Group or Account # on ID Card**: _____

2. Request

Information Requested from Records Maintained by Cigna

☐ 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 Cigna ID Card.)*

☐ Enrollment or eligibility information that Cigna 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 Cigna HealthCare Medical benefits.

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

3. Diagnosis and Treatment Code Information

You are encouraged to contact your Health Care Professional as the person responsible for providing Cigna with this information for their interpretation of this information and its relevance to your health.

Your Request:

Check the box(es) next to the information you want. Provide the names of the health care professional(s), their address(es) and the date(s) of the service or treatment. Please note that this information is generally available only for two years (24 months) after the date of the treatment or service. We may be able to retrieve older information in our archived files, but that will take additional time.

□ Diagnosis Codes *(and their standard definitions)* □ Treatment Codes *(and their standard definitions)*

Healthcare Professional(s) who provided the service or treatment		**Date(s) of Service**	
Name(s)	Addresses	First date of treatment	Last date of treatment

Please Note

- If the information on this form is not complete, Cigna will return the form to you, and this request will not be considered until Cigna 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.

4. Signature

I have read and understand the above information: (Print name) _____ 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 including furnishing a copy of the health care power of attorney or other relevant document.

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:

Fax to: 877.815.4827 or 859.410.2419
Or
Mail to: Cigna HEALTHCARE CENTRAL HIPAA UNIT
PO Box 188014
Chattanooga, TN 37422

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