REQUEST FOR CONFIDENTIAL COMMUNICATION

This form will allow me, as a Cigna Healthcare customer to request to receive communications of Protected Health Information (PHI) about me by alternative means or at alternative locations.

If a request is made for an alternate location, I understand correspondence will continue to be addressed to me, but will be mailed to the address I provide below. I understand all customer correspondence to me will be mailed to this alternate address whether or not it contains any confidential information about me. I understand that this request may be denied if it cannot reasonably be accommodated.

Note: If your request is granted, it will affect only written and oral communications by Cigna Healthcare. If you also wish another group health plan, physician or anyone outside of Cigna Healthcare to make this change, you must obtain their agreement separately.

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): _____

Current address on file: _____

_____

Medicare ID #: _____ Customer ID card # (if applicable): _____

REQUEST

I request to receive communications of my PHI from Cigna Healthcare:

☐ By alternate means or location (please describe and provide address): _____

_____

PLEASE NOTE

- Communications containing your PHI will to be sent to the address you have provided on this form.
- If an alternate address is approved, it may be shown on correspondence about you that Cigna Healthcare sends to others, such as your provider.
- If the information on this form is not complete, Cigna Healthcare will return the form to you, and this request may not be considered until Cigna Healthcare receives complete information.
- If your customer ID or date of birth changes, a new form must be submitted.
- You may change or revoke this request by sending a written request to Cigna Healthcare at the address below. You can obtain a Change/Revoke form by calling Cigna Healthcare customer service at the number on your Cigna Healthcare ID card.

Please complete the other side.

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.

We recommend that you keep a copy of your completed form for your records. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.

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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