



Request for Restriction of Use and Disclosure of Protected Health Information

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE^{®*} CUSTOMER, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI). I UNDERSTAND CIGNA HEALTHCARE WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY; HOWEVER, CIGNA HEALTHCARE IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

Note: If your request for restrictions is granted, it will affect only written and oral communications by CIGNA HealthCare. If you also wish your employer, 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): _____

Social Security # (Optional): _____ Customer ID card # (if applicable): _____

Group or Account # on ID card: _____

Subscriber Name (if different from Customer): _____

Subscriber's Relationship to Customer: _____ Subscriber's Employer Name: _____

Subscriber's Social Security # (if different from Customer) (Optional): _____

If you have additional coverage with CIGNA other than that which is described above, please complete the following information as well:

Other Employer Name: _____

Customer ID card #: _____ Group or Account # on ID card: _____

Does this request apply to all coverage? Yes No

CIGNA HealthCare will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA HealthCare programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

REQUESTED RESTRICTIONS

Please describe your request: _____

Please Indicate Below If You Wish the Following Access Restriction to Apply:

I wish to deny other family members covered under my policy access to my PHI via phone and Internet. If you make this election and you are not the Subscriber, you will not be able to access your information on the Internet. You will need to call the number on your or the Subscriber's ID card to obtain information by phone. (The Subscriber will still be able to obtain his/her own PHI via phone and Internet.) Important: If you wish to implement this type of restriction, you must complete the verification question section on page 2.

Please Complete Form On Next Page ➡

VERIFICATION QUESTIONS — (This section applies only to requests for access restrictions.)

The answers you provide below will be used to verify your identity if you call for your protected health information. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

4 digit PIN (you may use any four digit number): _____

What is your mother's date of birth: (answer in the following 8-digit format: 11231949 for November 23, 1949) _____

You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date.

For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232015 (November 23, 2015) because 2015 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference.

PLEASE NOTE

- *If you are not the Subscriber, any check payment for services you receive that is not sent to the health provider will be sent to the Subscriber. Therefore, a Subscriber may receive a check that may prompt questions to you about the services rendered.*
- *If the Subscriber is enrolled in a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), or Health Savings Account (HSA), he/she will also receive an Explanation of Benefits (EOB) for any claim submitted for reimbursement. In many cases, claims submitted for payment by the Subscriber's health benefit plan will be automatically submitted to his/her FSA or HSA for reimbursement.*
- *Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you.*
- *If any information on this form is not complete, CIGNA HealthCare will return the form to you, and your restriction request will not be considered until CIGNA HealthCare receives complete information.*
- *If your Customer ID or date of birth is changed in our system, another form will need to be completed at that time.*
- *If either the Customer or Group changes to a different type of health care benefits coverage provided by CIGNA HealthCare, another form will need to be completed at that time.*
- *You may change or revoke this restriction by sending a written request to CIGNA HealthCare, Central HIPAA Unit, at the address shown on page 3. You can obtain a Change/Revoke form by calling CIGNA HealthCare Customer Service at the number on your CIGNA HealthCare ID card or on website at www.CIGNA.com/privacy/privacy_healthcare_forms.html.*

SIGNATURE

I have read and understand the above information:

Date: _____

Signature of Customer, Parent/Guardian, Personal Representative: _____

Relationship if signed by other than Customer: _____

Note: 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: Customer is a minor ____ years of age.

If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's protected health information, you must:

1. provide evidence that the parental rights of the other parent have been terminated, or
2. obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's protected health information.

Please Return This Completed Form To:

CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 188014 • Chattanooga TN 37422

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