



Change/Revoke Request

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE®* CUSTOMER, TO REQUEST A CHANGE OR REVOCATION TO A PREVIOUSLY-APPROVED REQUEST FOR RESTRICTION, CONFIDENTIAL COMMUNICATIONS, PERSONAL REPRESENTATIVE, AUTHORIZATION, OR STATEMENT OF DISAGREEMENT. I UNDERSTAND BY COMPLETING AND SIGNING THIS FORM, I AUTHORIZE CIGNA HEALTHCARE TO CHANGE OR REVOKE A PREVIOUSLY-APPROVED REQUEST.

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 described above, please complete the following information as well:

Other Employer Name: _____

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

RESTRICTION

Please complete this section ONLY if you have an active privacy restriction on file with CIGNA HealthCare.

- I wish to revoke my restriction to deny other family members covered under my policy access to my Protected Health Information (PHI) via phone and internet.
- I wish to revoke all other restrictions. Please describe the specific restriction request you wish to revoke: _____

- I wish to change the answers to my verification questions:

If you checked box 3 above, you must provide the updated answers that you wish to use going forward:

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

CONFIDENTIAL COMMUNICATIONS

Please complete this section ONLY if you have an active confidential communications address on file with CIGNA HealthCare.

- I wish to revoke my confidential communications address.
- I wish to change my confidential communications address.

If you checked box 2 above, you must provide the updated address that you wish to use going forward: _____

Please Complete Next Page ➡

PERSONAL REPRESENTATIVE

Please complete this section ONLY if you have an active Personal Representative on file with CIGNA HealthCare.

1. I wish to revoke my Personal Representative.
2. I wish to change my Personal Representative information. Please check what you want to change and provide the updated information in the space provided:
 - 2a. Personal Representative's name: _____
 - 2b. Personal Representative's address: _____
 - 2c. Personal Representative's Date of Birth (answer in the following 8-digit format: 11231949 for November 23, 1949):

 - 2d. Personal Representative's verification questions:

If you checked box 2d above, you must provide the updated answers that you wish to use going forward:

- 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.

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

PRIVACY AUTHORIZATION REQUEST

Please complete this section ONLY if you have an active privacy authorization on file with CIGNA HealthCare.

- I wish to revoke my Privacy Authorization.
- Name of the Individual(s) or Company(ies) that are no longer authorized to receive my PHI: _____
 - Specific information that the above-revoked Authorization allowed (e.g., claims status, medical information, eligibility): _____

STATEMENT OF DISAGREEMENT

Please complete this section ONLY if you previously submitted either a Statement of Disagreement or a request to forward information related to a denial of your request to amend PHI.

- I wish to revoke my request to have some or all of the following information forwarded when CIGNA HealthCare sends correspondence concerning the disputed information: my request to amend PHI, the CIGNA HealthCare denial, any Statement of Disagreement, and any CIGNA HealthCare rebuttal.

PLEASE NOTE

- *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 receives complete information.*
- *If any enrollment information such as Social Security Number (SSN), your Customer ID or date of birth is changed another form will need to be completed at that time.*
- *If either the Customer or Group Subscriber changes health care benefits coverage within CIGNA HealthCare, another form will need to be completed at that time.*

Please Complete Next Page ➡

SIGNATURE AND NOTARIZATION

If your request is regarding a Restriction, Privacy Authorization, or Statement of Disagreement, please complete the signature section labeled A. If your request is regarding a Personal Representative or Confidential Communications, please complete the signature and notarization section labeled B.

A. SIGNATURE

I have read and understand the above information:	Date: _____
Signature of Customer, Parent/Guardian, Personal Representative if available: _____	
Relationship if signed by other than Customer: _____	
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: 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.	

B. SIGNATURE AND NOTARIZATION

I have read and understand the above information:	Date: _____
Signature of Customer, Parent/Guardian, Personal Representative if available: _____	
Relationship if signed by other than Customer: _____	
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: 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.	
State of _____)	
_____) ss.	
County of _____)	
On this the ____ day of _____, 20____, before me, _____ (Notary Public), the undersigned officer, personally appeared _____ (Customer or legal rep. name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.	
In witness whereof I hereunto set my hand.	
_____ Notary Public	
My Commission expires: _____	

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Please Return This Completed Form To:
CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 188014 • Chattanooga, TN 37422