



NAME
 PCP
 PCP PHONE
 ID #

GROUP
 MOD #

COPAYS
 OV ER RX
 VIS
 MED REC #

**CIGNA Medical Group (CMG)
 Request To Amend Protected Health Information**

Please complete this form to request an amendment to your Protected Health Information. Your signature must be notarized if you are returning this request by mail. You may complete this form and have your signature verified at the check-in desk of any healthcare center.

Please note that if the CIGNA Medical Group was not the originator of the information you are requesting to amend, you should contact that person directly to amend the information. For example, this would apply to a provider outside the CMG or your insurance company. CMG may not be able to change the information created by someone else and we may have to deny your request.

PATIENT NAME:		DATE OF BIRTH:		MEMBER ID# (If applicable):	
ADDRESS (Street):		CITY:		STATE:	ZIP CODE:
TELEPHONE #:					

Protected Health Information requested to be amended (including Dates of Service):

Specify change requested:

Reason for requested amendment:

If CIGNA Medical Group approves your request to amend, the amended information will be used and contained in all future disclosures. We will also provide the amendment to persons we know have previously received the information, as well as persons you identify below.

Name/address of individuals/organizations to whom you request amended Protected Health Information be sent, if request is approved:

Signature of Patient/Representative Requesting Amendment: _____ Relationship to Patient: _____ Date: _____

Signature of Notary/Witness: _____ Date: _____ Stamp: _____
 (If Notarized)

FOR CMG USE ONLY:

APPROVED BY: _____ Date: _____

DENIED BY: _____ Date: _____

Notification Letter sent on date: _____