



# Request for Confidential Communications

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 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

## REQUEST

1. I request to receive communications of my PHI from CIGNA HealthCare:

By alternate means or location (please describe and provide address): \_\_\_\_\_

Reason why the alternate means or location is necessary: \_\_\_\_\_

2. Restriction request: (Please indicate by checking the item below.)

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.)*

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.

Please Complete Form On Next Page ➡

## **VERIFICATION QUESTIONS** (Required for Request #2 only.)

**The answers you provide will be used to verify your identity if you call for your PHI. You must answer these questions if you checked box #2 in the Request section above. 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 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 containing your PHI will 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 is changed, 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 request by sending a written request to CIGNA HealthCare, Central HIPAA Unit, at the address 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.*

*Please Complete Form On Next Page ➡*

