



Statement of Disagreement/Request to Forward Denial of Amendment Request

THIS FORM WILL ALLOW ME TO PROVIDE A STATEMENT OF DISAGREEMENT TO THE CIGNA HEALTHCARE* DENIAL OF MY REQUEST TO AMEND MY PRIVATE HEALTH INFORMATION (PHI) THAT CIGNA HEALTHCARE MAINTAINS. I UNDERSTAND IF I DO NOT WISH TO SUBMIT A WRITTEN STATEMENT OF DISAGREEMENT, I MAY STILL REQUEST THAT THE CIGNA HEALTHCARE DENIAL OF MY AMENDMENT REQUEST BE FORWARDED.

PLEASE NOTE: If you complete this form and your or the Subscriber's employer benefit plan receives reports that contain your disputed PHI, we are required by law to forward to your or the Subscriber's employer your request to amend PHI, the CIGNA HealthCare denial, this form, including any Statement of Disagreement, and any CIGNA HealthCare rebuttal.

VERIFICATION – (Please Print)

Identification of Member/Participant: (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: _____ Date of Birth: _____
Phone number where we can reach you if we need to contact you to process your request (required): _____
Social Security #: _____ Member/Participant ID card # (if applicable): _____
Group or Account # on ID card: _____ Subscriber Name (if different from Member/Participant): _____
Subscriber's Relationship to Member/Participant: _____ Subscriber's Employer Name: _____
Subscriber's Social Security # (if different from Member/Participant): _____

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

Other Employer Name: _____
Member/Participant ID card #: _____ Group or Account # on ID card: _____

- *Submission of this form will not lead to the amendment of your information.*
- *If CIGNA HealthCare was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. For example, this would apply to your diagnosis, the date of service or the treatment you received. If the provider consents to amend your information and notifies CIGNA HealthCare, we will change the information in our records. In that case, it would not be necessary to submit this form.*

PHI amendment request that was denied and is the subject of your statement of disagreement: _____
Date of disputed PHI, if applicable: _____

STATEMENT OF DISAGREEMENT (Complete if you wish to submit a Statement of Disagreement)

Describe why you disagree with the denial to amend PHI (Please continue on second page if necessary): _____

CIGNA HealthCare will forward your request to amend your PHI, the CIGNA HealthCare denial, this form, including any Statement of Disagreement, and any CIGNA HealthCare rebuttal when sending correspondence containing the disputed information. We will not forward this information with correspondence to you or the Subscriber.

If you do not wish to submit a Statement of Disagreement, but would like your request to amend PHI and the CIGNA HealthCare denial to be forwarded when CIGNA HealthCare sends correspondence containing the disputed information, please check the box at the left.

Please Complete Form On Next Page ➡

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 has received complete information.*
- *If your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.*
- *If either the Member/Participant 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 below. You can obtain a Change/Revoke form by calling CIGNA HealthCare Member Services at the number on your CIGNA HealthCare ID card.*

SIGNATURE

I have read and understand the above information:	Date: _____
Signature of Member/Participant, Parent/Guardian, if available: _____	
Relationship if signed by other than Member/Participant: _____	
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 Member/Participant is unable to give consent because of age, complete the following: Member/Participant 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.

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Please Return This Completed Form To:

CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 5400 • Scranton PA 18505