



Request for Accounting

BY COMPLETING AND SUBMITTING THIS FORM, I AM REQUESTING AN ACCOUNTING OF MY PRIVATE HEALTH INFORMATION (PHI).

I understand that such accounting will be limited to disclosures that were not for the purposes of treatment, payment or health plan operations and for which I have not provided a written authorization. I realize that most disclosures of PHI are for treatment, payment or health plan operations. The accounting will not include any information disclosed prior to April 14, 2003.

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:

Subscriber's Employer Name: _____

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

REQUEST

I am requesting information about disclosures of the following type of information:

- Medical care
- Dental care
- Mental health/behavioral health care (Please make sure you have coverage through CIGNA Behavioral Health before you request this information.)

Send to the following address: _____

PLEASE NOTE

- The accounting will not include periods prior to April 14, 2003.
- One accounting per 12-month period is provided free; CIGNA HealthCare may charge for any additional accounting.
- This accounting of your private (protected) information **only includes disclosures made by CIGNA HealthCare** and its affiliates. It does not include disclosures that may have been made by the subscriber's employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.
- I understand that if the information on this form is not complete CIGNA HealthCare will return the form to me, and this request will not be considered until it has received complete information.
- If any enrollment information such as Social Security Number (SSN), Member 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.

SIGNATURE

I have read and understand the above information: _____ Date: _____

Signature of Member/Participant, Parent/Guardian, Personal Representative: _____

Relationship if person signing is 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 request is made by a Parent/Guardian, 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.

Signature of Member/Participant, Parent/Guardian, Personal Representative: _____

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Please Return This Completed Form To:

CIGNA HEALTHCARE • PRIVACY OFFICE • PO Box 5400 • Scranton PA 18505