Request for Restriction of Use and Disclosure of Private Health Information

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE* MEMBER/PARTICIPANT, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PRIVATE HEALTH INFORMATION (PHI). I UNDERSTAND CIGNA HEALTHCARE WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY; HOWEVER CIGNA HEALTHCARE IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

Note: If your request for restrictions 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 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 # (Optional): _________________________________ 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) (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: ____

Member/Participant ID card #: ________________________________ Group or Account # on ID card: ______________________________

Does this request apply to all coverage? ☐ Yes ☐ No

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.

REQUESTED RESTRICTIONS

☐ Please describe your request: ____

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Please Indicate Below If You Wish the Following Access Restriction to Apply:

☐ **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.) Important: If you wish to implement this type of restriction, you must complete the verification question section on page 2.

Please Complete Form On Next Page ➥

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VERIFICATION QUESTIONS – (This section applies only to requests for access restrictions.)

The answers you provide below will be used to verify your identity if you call for your private health information. 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.

Last 4 digits of your favorite credit card (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 11232010 (November 23, 2010) because 2010 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.

YOUR PREFERENCES

You are not required to complete this section. You should only complete this section if you wish to request not to be contacted regarding programs offered by CIGNA, its agents or subsidiaries as specified on this form except where required for administration of the benefit plan, by law or in direct response to my request or inquiry. Important: Even if you choose this restriction, CIGNA must still contact you with specific information related to your benefit plan or where required by law.

If you wish to proceed with this particular request, please check the types of outreach that you wish to restrict from the list below:

- ☐ **Global Opt Out** – I elect not to receive any phone or written contact from CIGNA HealthCare medical, vision, pharmacy, behavioral health and dental programs except where it is required for administration of the benefit plan or by law.
- ☐ **E-Mail** – I elect not to receive e-mail correspondence.
- ☐ **Surveys** – I elect not to receive surveys for any reason, except where required for the administration of the benefit plan or by law or in direct response to my request or inquiry.
- ☐ **Printed Materials** – I elect not to receive printed materials, including educational materials, brochures and newsletters, except where required for administration of the benefit plan, by law or in direct response to my request or inquiry.
- ☐ **Letters and Correspondence** – I elect not to receive any letter or correspondence except where required for administration of the benefit plan, by law or in direct response to my request or inquiry. This includes routine preventive health reminders.
- ☐ **Phone Calls** – I elect not to receive any phone calls, except where required for the administration of the benefit plan and or by law or in direct response to my request or inquiry.

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 Explanation of Benefits (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, including communications containing PHI, will continue to be sent to the current address we have on file for you.*
- *If any information on this form is not complete, CIGNA HealthCare will return the form to you, and your restriction request will not be considered until CIGNA HealthCare receives complete information.*
- *If your Member/Participant ID or date of birth is changed in our system, 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 restriction by sending a written request to CIGNA HealthCare, Central HIPAA Unit, at the address shown on page 3. You can obtain a Change/Revoke form by calling CIGNA HealthCare Member Services at the number on your CIGNA HealthCare ID card or on website at* www.cigna.com/privacy/privacy_healthcare_forms.html.

Please Complete Form On Next Page ➥

SIGNATURE

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

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

Relationship if signed by other than Member/Participant: ____________________

Note: 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 a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's private health information, you must:

1. provide evidence that the parental rights of the other parent have been terminated, or
2. obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's private health information.

Please Return This Completed Form To:

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

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