



Request for Access to Health Care Information

This form will allow me, as a CIGNA Medicare Rx* Member to request access to Private Health Information (PHI) about me that CIGNA Medicare ServicesSM maintains and that was created or received by CIGNA Medicare Services during my membership in the program.

VERIFICATION – (Please Print)

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

Name of Member: _____

Date of Birth: _____

Phone number where we can reach you if we need to contact you to process your request (required):

Address: _____

Medicare ID #: _____ Member ID card # (if applicable): _____

REQUEST

Information Requested from Records Maintained by CIGNA Medicare Services.

- Adjudicated (processed) claims: This is a summary of claims paid or denied. (This does not include information on claims received but not yet processed – if you would like the status of those claims you may call Member Services at the toll free number listed on your CIGNA Medicare Services ID card.)
- Enrollment or eligibility information that CIGNA Medicare Services has received from the Member. (This includes information such as name, address, phone number, Medicare ID number, etc.)
- Other information (please describe): _____

Most information is maintained and will be provided for a 24 month period. It may not be possible to provide information beyond that period.

