



Request for Accounting of Private Health Information Disclosures

By completing and submitting these forms 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 Private Health Information (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: *(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): _____

PLEASE NOTE

- The accounting will not include periods prior to April 14, 2003.
- One accounting per 12-month period is provided free; CIGNA Medicare Services may charge for any additional accounting.
- This accounting of your private (protected) information only includes disclosures made by CIGNA Medicare Services and its affiliates.
- I understand that if the information on this form is not complete CIGNA Medicare Services will return the form to me, and this request will not be considered until complete information is received.
- 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.

Please Complete Other Side

SIGNATURE

I have read and understand the information on this form. Date: _____

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

Relationship if person signing is other than Member: _____

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 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, Parent/Guardian, Personal Representative: _____

Please Maintain a copy of this form for your records.

Please Return This Completed Form To:

CIGNA Medicare Services • PO Box 269005 • Weston, FL 33326-9927

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