



Statement of Disagreement/Request to Forward Denial of Amendment Request

This form will allow me to provide a Statement of Disagreement to the CIGNA Medicare Services* denial of my request to amend my Private Health Information (PHI) that CIGNA Medicare Services maintains. I understand if I do not wish to submit a written Statement of Disagreement, I may still request that the CIGNA Medicare Services denial of my amendment request be forwarded.

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):

Current Address on file: _____

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

- Submission of this form will not lead to the amendment of your information.
- If CIGNA Medicare ServicesSM 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 originator provides consent to amend your information and notifies CIGNA Medicare Services, 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 a separate sheet of paper if necessary): _____

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

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

PLEASE NOTE

- If the information on this form is not complete, CIGNA Medicare Services will return the form to you, and this request will not be considered until CIGNA Medicare Services has received complete information.
- If your date of birth or Member ID changes, a new form must be completed at that time.
- You may change or revoke this request by sending a written request to CIGNA Medicare Services at the address below. You can obtain a Change/Revoke form by calling CIGNA Member Services at the number on your CIGNA Medicare Services ID card.

SIGNATURE

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

Signature of Member, Parent/Guardian, if available: _____

Relationship if signed by 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 Member is unable to give consent because of age, 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.

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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