# Cigna Global Health Benefits℠ HIPPA Request to Amend Individually Identifiable Health Information

This form will allow me to request an amendment to my individually identifiable health care information that Cigna Global Health Benefits maintains.

## VERIFICATION:

**Identification of member/participant: The following information is needed for verification. Complete all applicable items.**

Name of Member/Participant Requesting Access | Date of Birth | Member #

Subscriber's Name (if different from Member) | Subscriber's Relationship to Member

Subscriber's Employer Name | Subscriber's Member Number

## INFORMATION REQUESTED TO BE AMENDED:

*Please note that if Cigna Global Health Benefits was not the originator of the information you are requesting to amend, Cigna Global Health Benefits cannot amend such information. You must contact the originator of the information directly to amend such information. Examples of such originators of information include your physician and other health care providers.*

**Describe the individually identifiable health information you would like amended:**

**Specify change/amendment requested:**

**Date(s) of service associated with the individually identifiable health information *(if applicable)*:**

**Reason for requested amendment:**

**If Cigna Global Health Benefits approves your request to amend, the amended information will be used and contained in all future disclosures including correspondence. We will also provide the amendment to persons we know have previously received the information as well as persons you identify below.**

**Name/address of individuals/organizations to whom you request amended information to be sent if request is approved:**

I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my request to amend will not be implemented until all the information is received complete and processed.

**Please return the signed and completed form to the following address:**

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

**I have read and understand the above information:**

Date: _____ Signature of Authorizing Member/Participant: _____

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of _____ years of age or is unable to give consent, because: _____

Signature of Parent/Guardian/POA: _____ Relationship: _____

Signature of Personal Representative: _____ Relationship: _____





Clear Form