Request for Access to Protected Health Information

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE®* CUSTOMER, TO REQUEST ACCESS TO PROTECTED HEALTH INFORMATION (PHI) ABOUT ME THAT CIGNA HEALTHCARE MAINTAINS AND THAT WAS CREATED OR RECEIVED BY CIGNA HEALTHCARE DURING THE TIME OF MY COVERAGE WITH THE PLAN IDENTIFIED BELOW.

VERIFICATION – (Please Print)

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

Name of Customer: _____ Date of Birth: _____

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

Social Security # (Optional): _____ Customer ID card # (if applicable): _____

Group or Account # on ID card: _____ Subscriber Name (if different from Customer): _____

Subscriber's Relationship to Customer: _____ Subscriber's Employer Name: _____

Subscriber's Social Security # (if different from Customer) (Optional): _____

If you have additional coverage with CIGNA, other than described above, please complete the following information as well:

Other Employer Name: _____

Customer ID card #: _____ Group or Account # on ID card: _____

REQUEST

Address for CIGNA HealthCare to send requested information:

Information Requested from Records Maintained by CIGNA HealthCare

☐ 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 Customer Service at the toll free number listed on the CIGNA HealthCare ID card.)

☐ Enrollment or eligibility information that CIGNA HealthCare has received from the Subscriber's employer or from the Subscriber/Customer.
(This includes information such as name, address, phone number, SSN etc.)

☐ Case management and medical utilization management information (CM/MM).

☐ Other information *(please describe)*: _____

_____

Type of Information Requested:

☐ I request the information checked above for my CIGNA HealthCare Medical benefits.

☐ I request the information checked above for my CIGNA Behavioral Health benefits.
(Please make sure you have coverage through CIGNA Behavioral Health before you request this information.)

☐ I request the information checked above for my CIGNA Dental benefits.
(Please make sure you have coverage through CIGNA Dental before you request this information.)

Most information is maintained and will be provided for a 24 month period.
There may be other PHI created or maintained by the Subscriber's employer/group health plan and/or its business associates and not included in this response for access. You should contact the employer to obtain any additional information.

Please Complete Form On Next Page ➥

PLEASE NOTE

- *If the information on this form is not complete, CIGNA HealthCare will return the form to you, and this request will not be considered until CIGNA HealthCare receives complete information.*
- *You may not be entitled to receive all of your PHI, and will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.*

SIGNATURE AND NOTARIZATION

To safeguard your privacy and help make sure no one else is requesting access to your PHI, this request must be notarized. (Notary services can often be provided free at a bank where you have an account.)

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

Signature of Customer, Parent/Guardian, Personal Representative if available: _____

Relationship if signed by other than Customer: _____

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: Customer 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.

State of)
) ss.
County of)

On this the _____ day of _____ , 20___, before me, _____(Notary Public), the undersigned officer, personally appeared _____ (member or legal rep. name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand.

_____

Notary Public

My Commission expires: _____

Please Return This Completed Form To:

CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 188014 • Chattanooga TN 37422