REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

By completing and submitting this form, I understand that such accounting will be limited to certain disclosures made in the six years prior to the date of this form that were not for the purposes of treatment, payment or health plan operations and for which my verbal or written agreement was not required.

VERIFICATION – (Please print)

Identification of customer:

(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): _____

Address: _____

_____

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

PLEASE NOTE:

- One accounting per 12-month period is provided free; Cigna may charge for any additional accounting.
- This accounting of your protected health information only includes disclosures made by Cigna and its affiliates.
- I understand that if the information on this form is not complete Cigna 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), customer ID or date of birth is changed, another form will need to be completed at that time.

SIGNATURE

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

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

_____

Relationship, if signed by other than customer: _____

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If customer is unable to give consent because of age, 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.

COMPLETED FORM MAILING ADDRESSES

Please send your completed form to your plan's corresponding address below:

Cigna Medicare Advantage Plan

Cigna Privacy Office
PO Box 188014
Chattanooga, TN 37422

Cigna Medicare Prescription Drug Plan

Cigna
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.