REQUEST TO AMEND PROTECTED HEALTH INFORMATION

This form will allow me to request an amendment of my Protected Health Information (PHI) that Cigna Healthcare[SM] maintains.

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): _____

INFORMATION REQUESTED TO BE AMENDED

If Cigna Healthcare was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. If the originator consents to amend your information and notifies Cigna Healthcare, we will change the information in our records. In that case, it would not be necessary to submit this form.

If Cigna Healthcare approves your request to amend, the amended information will be used and included in all future disclosures, including correspondence. We will provide the amendment to persons who previously received the information if we believe they have relied or will rely on that information to your detriment. Also, we will provide the amendment to individuals/organizations you identify below.

Names/addresses of individuals/organizations to whom you request amended information be sent, if request is approved:

_____

_____

Describe the PHI you would like amended: _____

Specify change/amendment requested: _____

Date(s) of service associated with the PHI (if applicable): _____

Reason for requested amendment: _____

Please complete the other side.

PLEASE NOTE

- This amendment of your protected health information only includes information that Cigna Healthcare maintains.
- Your request may be denied. If it is denied, you will be notified in writing within 60 days. The denial will include instructions on how you can submit a written statement disagreeing with the denial.
- 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 has received complete information.

SIGNATURE

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

Signature of customer or 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

Medicare Privacy Office
Cigna Healthcare
PO Box 24207
Nashville, TN 37202

Cigna Medicare Prescription Drug Plan

Cigna Healthcare
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.