REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form will allow me, as a Cigna Healthcare℠ Customer, including Behavioral Health, 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 employment with the employer identified below. This form may also be used to request additional information about diagnosis and treatment codes. **All fields marked with * are mandatory.**

*1. 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:** _____

***Address on Record (required):** _____

_____

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

Last 4 Social Security # (optional): _____ ***Customer ID Card #:** _____

Group or Account # on ID Card: _____

Subscriber's Employer Name: _____

***Customer's Email Address:** _____

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

Other Employer Name: _____

Customer ID Card #: _____ **Group or Account # on ID Card:** _____

*2. 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 Member Services at the toll-free number listed on your or the Subscriber's 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): _____

_____

THE Cigna GROUP

***Type of Information Requested:**

☐ I request the information checked above for my Cigna Healthcare Medical benefits.

☐ I request the information checked above for my Behavioral Health benefits. *(Please make sure you have coverage through 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. It may not be possible to provide information beyond that period.

3. Diagnosis and Treatment Code Information

You are encouraged to contact your Health Care Professional as the person responsible for providing Cigna Healthcare with this information for their interpretation of this information and its relevance to your health.

Your Request:

Check the box(es) next to the information you want. Provide the names of the health care professional(s), their address(es) and the date(s) of the service or treatment. Please note that this information is generally available only for two years (24 months) after the date of the treatment or service. We may be able to retrieve older information in our archived files, but that will take additional time.

☐ Diagnosis Codes *(and their standard definitions)* ☐ Treatment Codes *(and their standard definitions)*

Health Care Professional(s) who provided the service or treatment

Name(s) _____

Address(es) _____

Name(s) _____

Address(es) _____

Date(s) of service

First date of treatment _____

Last date of treatment _____

First date of treatment _____

Last date of treatment _____

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.

*4. Signature

I have read and understand the above information:

(Print name) _____ 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, including furnishing a copy of the health care power of attorney or other relevant document.

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.

Please Return This Completed Form:

Fax to: 877.815.4827 or 859.410.2419

or

Mail to: Cigna Healthcare Central HIPAA Unit,
PO Box 188014,
Chattanooga, TN 37422.