REQUEST FOR ACCESS TO HEALTH CARE INFORMATION

This form will allow me, as a Cigna Healthcare[SM] customer to request access to Protected Health Information (PHI) about me that Cigna Healthcare maintains, that was created or received by Cigna Healthcare during my membership in the program, and that is used to make decisions about my benefits.

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): _____

Address: _____

_____

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

REQUEST

Information requested from records maintained by Cigna Healthcare

☐ Medical records ☐ Billing records

☐ 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 your Cigna Healthcare ID card.)

☐ Enrollment or eligibility information that Cigna Healthcare has received from the customer.
(This includes information such as name, address, phone number, Medicare ID number, etc.)

☐ Other information (please describe) _____

_____

Most information is maintained and will be provided for a 24-month period. It may not be possible to provide information beyond that period.

Please complete the other side.

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

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.