



CIGNA HealthCare

BY COMPLETING AND SUBMITTING THIS FORM, I AM REQUESTING AN ACCOUNTING OF MY PRIVATE HEALTH INFORMATION (PHI).

# Request for Accounting

I understand that such accounting will be limited to disclosures that were not for the purposes of treatment, payment or health plan operations and for which I have not provided a written authorization. I realize that most disclosures of PHI are for treatment, payment or health plan operations. The accounting will not include any information disclosed prior to April 14, 2003.

## VERIFICATION – (Please Print)

**Identification of Member/Participant:** (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ Member/Participant ID card # (if applicable): \_\_\_\_\_

Group or Account # on ID card: \_\_\_\_\_ Subscriber Name (if different from Member/Participant): \_\_\_\_\_

Subscriber's Relationship to Member/Participant: \_\_\_\_\_ Subscriber's Employer Name: \_\_\_\_\_

Subscriber's Social Security # (if different from Member/Participant): \_\_\_\_\_

## REQUEST

I am requesting information about disclosures of the following type of information:

Medical care

Dental care

Send to the following address: \_\_\_\_\_

## PLEASE NOTE

- The accounting will not include periods prior to April 14, 2003.
- One accounting per 12-month period is provided free; CIGNA HealthCare may charge for any additional accounting.
- This accounting of your private (protected) information **only includes disclosures made by CIGNA HealthCare** and its affiliates. It does not include disclosures that may have been made by the subscriber's employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.
- I understand that if the information on this form is not complete CIGNA HealthCare will return the form to me, and this request will not be considered until it has received complete information.
- If any enrollment information such as Social Security Number (SSN), Member ID or Date of Birth is changed, another form will need to be completed at that time.
- If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CIGNA HealthCare, another form will need to be completed at that time.

## SIGNATURE

I have read and understand the above information: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Member/Participant, Parent/Guardian, Personal Representative: \_\_\_\_\_

Relationship if person signing is other than Member/Participant: \_\_\_\_\_

**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: Member/Participant 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.

Signature of Member/Participant, Parent/Guardian, Personal Representative: \_\_\_\_\_

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these operating subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

Please Return This Completed Form To: